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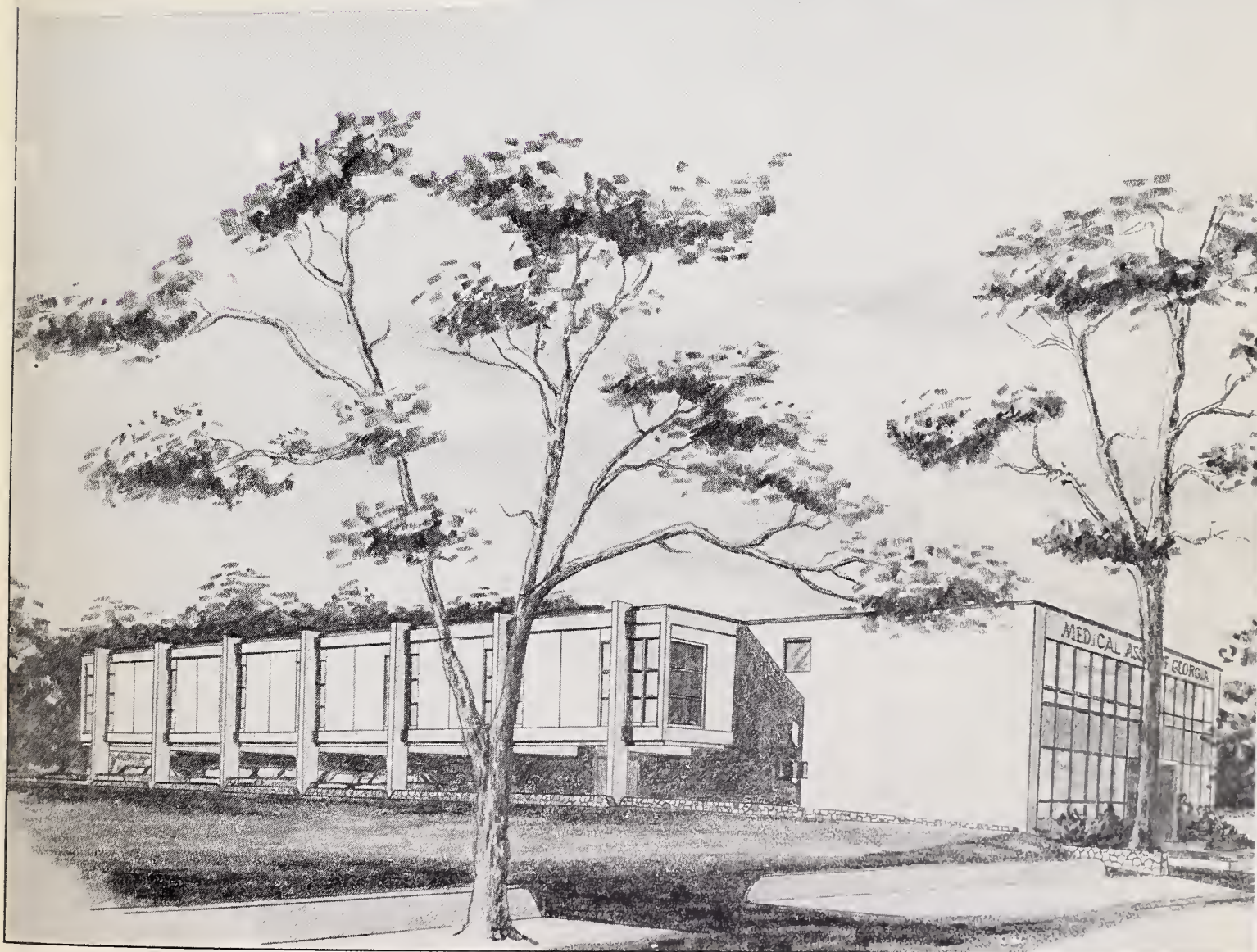
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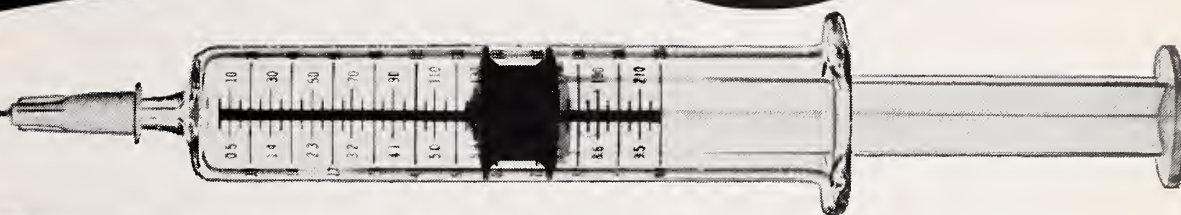
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Contents

See page 27 for the 116th MAG Annual Session
Hotel and Motel Reservation Form

Scientific Articles

SOME IMMUNOLOGIC ASPECTS OF CARDIAC TRANSPLANTATION

John R. Montgomery, M.D.

1

DICLOXACILLIN IN THE TREATMENT OF PURE STAPHYLOCOCCAL AND OF MIXED STAPHYLOCOCCAL- STREPTOCOCCAL INFECTIONS OF CHILDHOOD

Sanford J. Matthews, M.D.

8

Special Articles

RICHARD DENNIS ARNOLD, SAVANNAH PHYSICIAN AND UNIONIST IN THE YEARS OF CRISIS 1832-1861

Steve Gurr

11

HEART RATE MEASUREMENTS OF DRIVERS WITH THE HIGHWAY SYSTEMS RESEARCH CAR

Fletcher N. Platt

16

RX FOR GOOD GOVERNMENT—A CONGRESSMAN'S VIEW

Hon. G. Elliot Hagan, N.C.

23

Editorials

OUR NEW HEADQUARTERS—HERE AND NOW

J. G. McDaniel, M.D.

28

Features

President's Letter	30
Cancer Page	31
Heart Page	34
Legal Page	36
Highlights of AMA House of Delegates Meeting	38
Month in Washington	42

The Association

Societies	38
Personals	38
Deaths	38
Calendar	10

Cover

Drawing of MAG Headquarters Building by Thompson and Hancock, Architects. Cover design by Marie Seaman.

Some Immunologic Aspects of Cardiac Transplantation* †

JOHN R. MONTGOMERY,‡ M.D., *Houston, Tex.*

THE PRINCIPAL PROBLEM in the transplantation of most human tissues (between other than identical twins) is rejection. Cardiac transplantation has proved to be no exception. The mechanisms of recognition and rejection of foreign substances by an organism are to a large extent responsible for that organism's survival in the evolutionary process. These mechanisms are therefore highly developed in man, and fortunately in most incidences not easily overcome. In order for transplantation to be useful in any case, except the rare instance of identical twins, methods will have to be developed to avoid or control the rejection reaction. The following is a presentation of some of the methods currently being used to attack the problem, and their application to the cardiac transplants carried out at the Texas Heart Institute of St. Luke's and Texas Children's Hospitals.

The "Rejection Arc"

When foreign substances are encountered by the immunologic apparatus of the body, a series of events is set in motion. These events might be viewed as analogous to an arc with an efferent (sensitizer) limb and an afferent (effector) limb. The efferent limb has to do with the recognition and processing of the substance, or antigen. This process involves phagocytosis by macrophages and polymorphonuclear cells, "processing" of the antigen and delivery to responding cells of the reticulo-

endothelial system; these cells are the plasma cells and lymphocytes (predominantly small lymphocytes). Some antigens appear to produce primarily a stimulation of the plasma cell series, leading to the production of circulating antibodies, and others stimulation of the lymphocyte series leading to delayed hypersensitivity type reactions. The delivery of the antibody, and/or sensitized lymphocytes to the antigen, and their reaction with it, constitute the afferent limb of the arc. This series of events is schematically shown in Figure 1. The rejection of transplanted tissues is thought to involve both cellular (delayed hypersensitivity) and humoral (antibody) participation, but primarily cellular. It is known that both participate in the rejection of transplanted kidneys.² The mechanisms are not so well worked out in the rejection of the transplanted heart, but there is no reason to think they are different.

Methods of Controlling Rejection Reaction

A. Avoidance: The degree of reaction described above appears to be proportional to the difference between the genetic makeup of the two individuals, i.e., the donor and the recipient. The more closely related the tissues, the less the reaction, so that tissues of a single individual may be transplanted from one body site to another without eliciting the rejection reaction. The same appears to be true of identical twins. Transplants between siblings or between a parent and a sibling have a better chance of success than do randomly selected donors and recipients.³ Experience with renal transplants has shown that matching donor and recipient according to blood type increases the chance for a successful transplant, at least in so far as immediate rejection

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† Presented at the 115th Annual Session of the Medical Association of Georgia, Savannah, Georgia, May 5, 1969.

‡ Assistant Professor of Pediatrics, Baylor College of Medicine, Houston, Texas.

reactions are concerned.⁴ From this knowledge, it becomes apparent that tissue matching improves the chances for graft take. Several methods have been evolved for attempting to select donors and recipients according to the similarity of their tissues. Since the lymphocyte appears to contain all the important tissue antigens, most of the tests devised so far involve this cell.⁵ The more common of the matching tests are as follows:

a. Blood Group Matching: Donor and recipient should match in so far as the major blood groups A, B, and O are concerned. This matching corresponds basically to the rules governing blood transfusions with one exception, the Rh factor. Experience with renal transplants has indicated that the Rh antigen is not a significant factor in tissue transplantation.⁶ Avoidance of ABO erythrocyte group incompatibilities apparently eliminates certain gross differences between donor and recipient.

b. Tissue Matching:

1. In Vivo Tests:

(a) "Third Man Test."⁷ In this test, a

skin graft from the prospective recipient is placed on a volunteer and a "first set" rejection allowed to take place. This procedure sensitizes the volunteer to the antigens present in the donor, and requires approximately 14 days. At the end of this period, skin grafts from the prospective donors are applied to the volunteer and a "second set" rejection reaction allowed to occur. The graft rejected most rapidly denotes the donor sharing the largest number of antigens in common with the recipient, and therefore, the best match. This test has several drawbacks: 1) It requires at least three weeks, 2) it detects only similarities and not differences between the donor and recipient, 3) it has not proven reliable in man.

(b) Normal Lymphocyte Transfer Test (NLT).⁸ For this test, peripheral lymphocytes are obtained from the potential recipient and from two or more volunteers who serve as controls. 5×10^6 lymphocytes from each are injected intradermally into separate sites on each of the prospective donors. The skin reaction is evaluated at 48 hours and the prospective donor show-

THE MECHANISM OF REJECTION

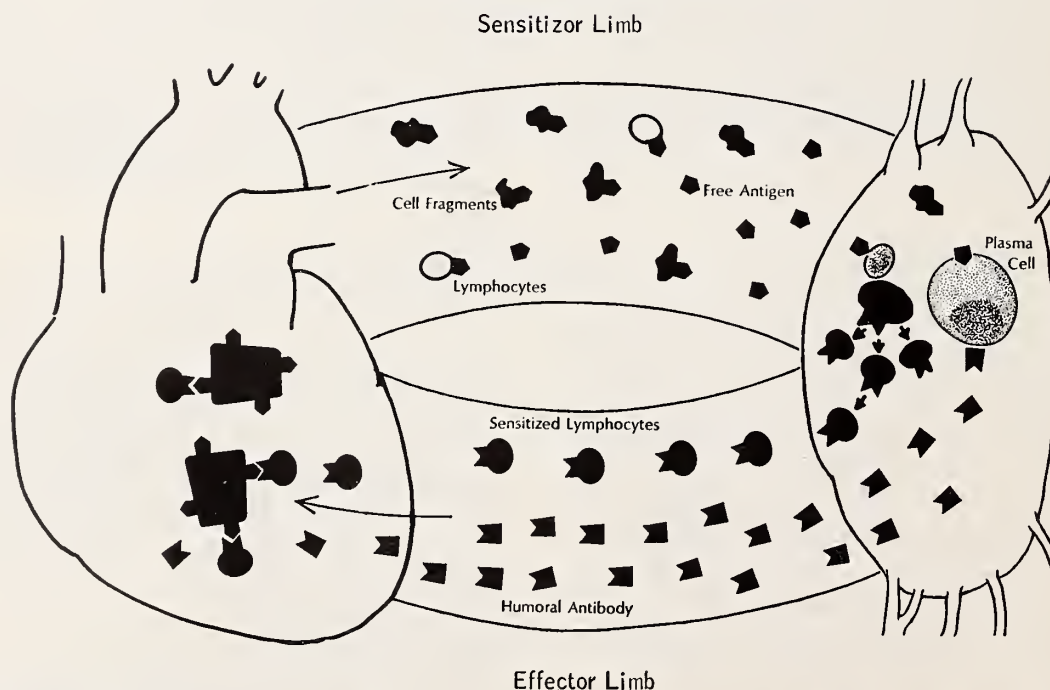


FIGURE 1: THE REJECTION ARC

Histocompatibility antigen from the transplanted heart comes in contact with small lymphocytes. These cells become sensitized and capable of reacting against the heart antigen. Plasma cells may be sensitized also and

produce antibody against heart tissue. This constitutes the afferent or sensitizer limb of the arc. The return of the sensitized lymphocytes and antibody to the heart via the circulation constitute the efferent or effector limb of the arc. The control point is the reticuloendothelial system, here shown as a lymph node.

ing the least reaction to the recipient's cells is chosen as the best match.

(c) Irradiated Hamster Test.⁹ A lethally irradiated hamster is used for observing lymphocyte reactions in this test. Being lethally irradiated, the animal is incapable of contributing to the reaction, and serves only as a test site. Approximately 30 hours after irradiation, the hamster is injected at separate sites with lymphocytes from the recipient and from each of the prospective donors; then mixtures of the recipient's lymphocytes, with each of the prospective donors' lymphocytes, are injected into other sites on the hamster's skin. The smallest reaction produced by these mixtures of cells indicates the best donor.

2. In Vitro Tests:

(a) Mixed Lymphocyte Culture Test (MLC).¹⁰ This test makes use of the fact that lymphocytes from genetically dissimilar individuals stimulate blast transformation when they are allowed to interact in tissue culture. Bach & Hirschhorn¹¹ have

shown that the intensity of this transformation is correlated with the degree of genetic difference between the individuals involved. Bach¹² has modified the test further by using Mitomycin C® to "paralyze" the lymphocytes (inhibit their DNA synthesis) of one subject so that a one-way stimulation may be evaluated (Fig. 2).

This test has the drawbacks of time required, and sensitivity. The test may be so sensitive that detection of acceptable matches in unrelated donors will be difficult. However, with further evaluation and in combination with lymphocyte typing, this difficulty may not be such a significant problem.

(b) Lymphocyte Typing. This test makes use of the fact that tissue antigens are represented on the surface of the lymphocytes. By using a panel of antisera directed against these antigens, persons who share antigens can be detected. The test is similar to red blood cell typing. Viable lymphocytes are obtained from peripheral

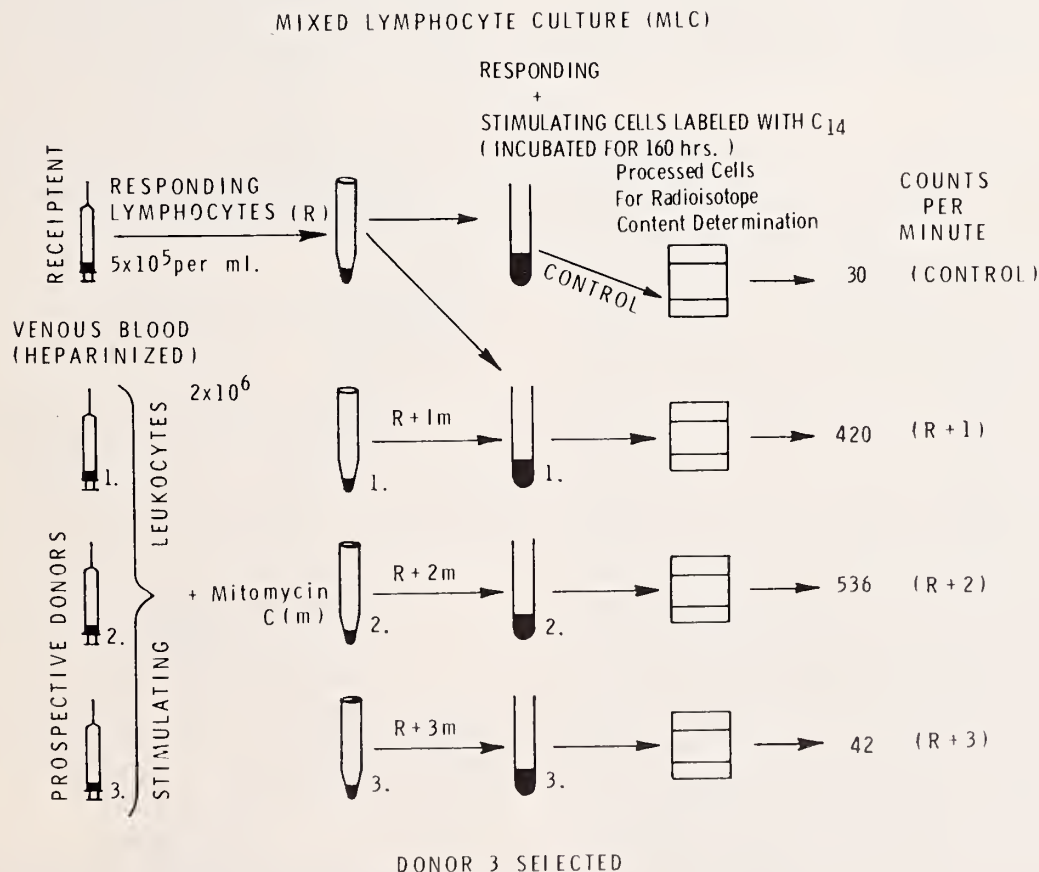


FIGURE 2

Potential donors' lymphocytes (1, 2 and 3) are treated with Mitomycin C in order to render them incapable of undergoing blast transformation. Then they are mixed with untreated lymphocytes from the recipient (R) and placed in tissue culture (center). Blast transformation is

determined after five days by measuring radioactive tracer uptake into DNA or counting transformed cells. The donor producing the least blast transformation would be the best match (No. 3).

blood and placed in small wells in plastic trays containing different antisera. The cells are then allowed to incubate with the antisera, and are observed for cytotoxic effects. In this manner, a "type" may be assigned to the individual and compared with that of prospective donors or recipients. The method used at the Texas Heart Institute is that of Terasaki.¹³ Comparison of antigens present in the donor and recipient has been grouped by Terasaki as follows: A: Identical (twins), B: No group mismatches, C: One group mismatch, D: Two or more group mismatches, and F: Positive cross match (the recipient's serum already contains antibodies against the donor's tissues). The number and importance of the human histocompatibility antigens are not clear at this time, but this method holds the most promise for the future success of organ transplantation.

From the series of cardiac transplants done at the Texas Heart Institute, it appears that, like renal transplants, the length of survival of the transplanted heart is directly related to the closeness of the tissue match.¹⁴

B. Immunosuppression: In all but identically matched donor and recipient, some method of attenuating the immune mechanism is necessary. The methods used clinically thus far have been: (1) radiation, (2) drugs, (3) depletion of lymphocytes. The principle of immunosuppression in all these methods is to deplete the lymphoid cells or to eliminate or attenuate their function. The drugs most commonly used are Azathioprine (Imuran®) and the corticosteroids. The use of a biological, antilymphocyte globulin (ALG) has recently been added to the immunosuppressive armamentarium. This product was first used in human cardiac transplants by the team at the Texas Heart Institute.¹⁵ ALG is made in horses injected with human thymus cells and represents antibody directed at the lymphoid cells believed to be responsible for rejection. Radiation produces lymphocyte destruction, or renders the cell incapable of cell division and function, thereby effectively reducing the number of potent lymphoid cells available for rejection. Lymphocyte depletion is also accomplished in some centers by removing the lymphocytes from thoracic duct lymph.¹⁶ The lymph is drained from the thoracic duct and the lymphocytes removed by centrifuga-

tion. The lymph is then returned to the circulation. To date, only the above-named drugs and antilymphocyte globulin have been used in the cardiac transplantation program at the Texas Heart Institute.

Detecting Rejection¹⁷

Rejection of the heart may be divided into two types: acute rejection and chronic rejection. Acute rejection may appear as early as the fifth postoperative day. Signs which arouse suspicion of rejection are: pericardial friction rub, evidence of congestive failure, temperature elevation, increasing heart rate, and malaise. Laboratory aids include: elevation of LDH-1, EKG changes, particularly decreased QRS voltage, and elevated white cell count. In chronic rejection, the signs and laboratory findings are much more subtle. Late rejection begins with a gradual loss of QRS voltage. There are usual-

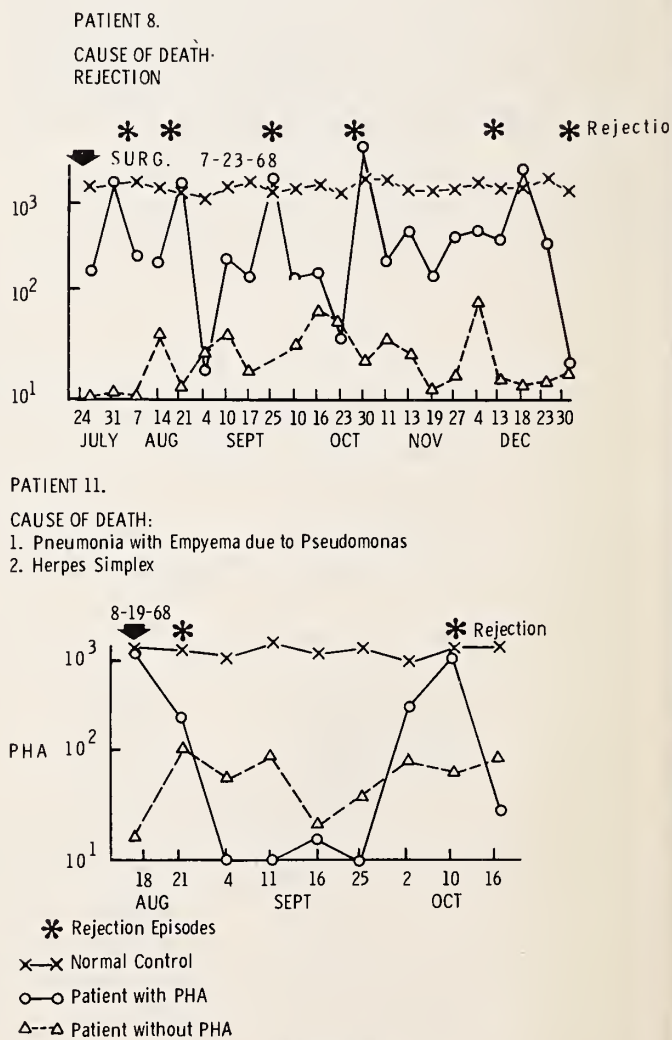


FIGURE 3

Phytohemagglutinin, an extract of the kidney bean, causes normally functioning lymphocytes to undergo blast transformation and synthesize DNA in vitro. If a radioactive precursor of DNA is added to the tissue cultures the amount of stimulation can be measured by the uptake of the radio label. This gives a measure of the function of the cells believed to be primarily responsible for the rejection of organ transplants.

ly few systemic complaints. If the EKG changes are not noted, and no change is made in the immunosuppressive treatment, further progression occurs, resulting in signs and symptoms of congestive heart failure, decrease in exercise tolerance and malaise. Death can occur suddenly in both acute and chronic rejection. The etiology of sudden death has not been determined, but it is speculated that infiltration of the heart by lymphoid cells may result in conduction problems. Laboratory tests are suggestive, but not diagnostic. LDH-1 is increased, but not markedly so. The white count may be mildly elevated, but is usually not helpful. In addition to routine laboratory tests, several experimental tests have been under evaluation as possible aids in measuring immunosuppression and detecting onset of rejection. The response of patient's peripheral lymphocytes to phytohemagglutinin (Figure 3) has been followed serially in all but four of the patients undergoing cardiac transplantation at the Texas Heart Institute. It has been shown that patients receiving immunosuppressive drugs show decreased responsiveness of their lymphocytes, when cultured with phytohemagglutinin (PHA).¹⁸ To date, no diagnostic findings have been noted in the results of PHA stimulation tests, but a pattern appears to be developing. Patients who show significant depression of PHA responsiveness of their

lymphocytes for prolonged periods have not experienced rejection reactions as severe nor as numerous as have those patients who show only transient or no depression. No patient has experienced a fatal rejection reaction while exhibiting prolonged depression of PHA responsiveness. However, several patients who exhibited prolonged depression of PHA responsiveness have had severe infections. Two of these patients were thought to have expired as a direct result of their infections. Therefore, it would appear that those patients in whom it is more difficult to suppress lymphocyte response are at high risk of rejection, while the more easily suppressed are at high risk of infection. These findings are demonstrated by the findings in a typical patient from each group shown in Figure 4.

Complications of Immunosuppression

Complications related to immune suppression in our patients have included: diabetes, Cushingoid changes, weight gain, bone marrow depression, psychological reactions, serum reactions, and infections.¹⁹ Infections have been primarily due to gram-negative organisms, but infections encountered in other immunosuppressed patients have also been noted in our series.²⁰ These have included Candida, herpes simplex, Listeria, and cytomegalovirus infections. The infections encountered, treatment and

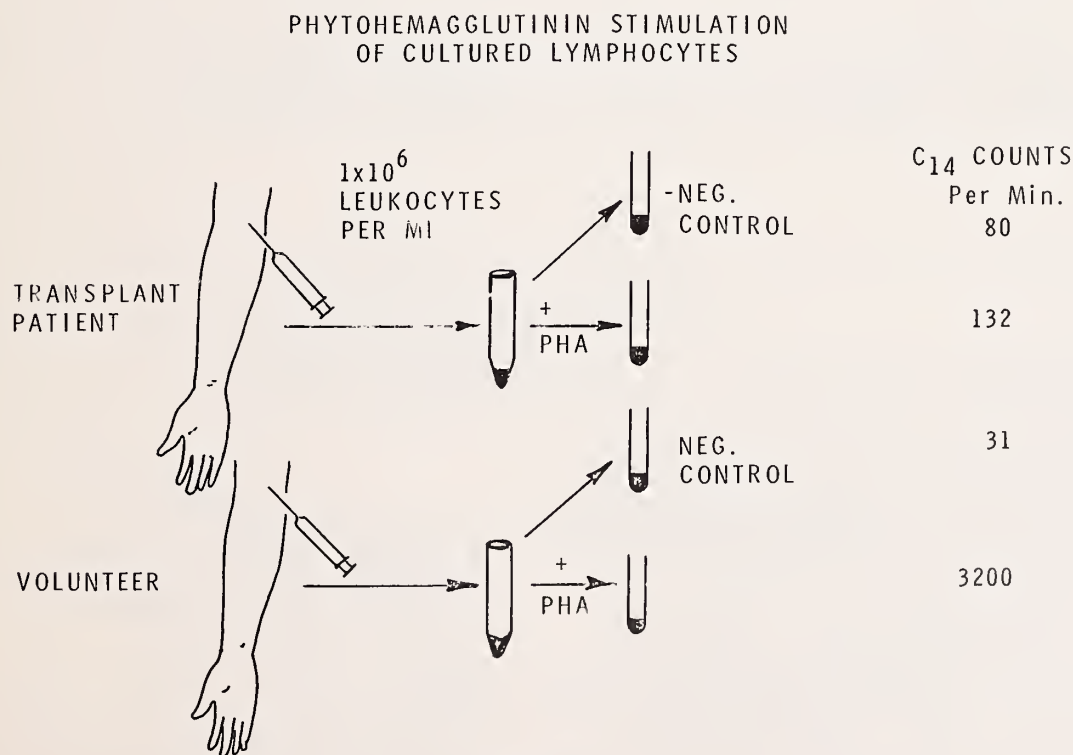


FIGURE 4

Patient 8 demonstrated poor suppression of lymphocyte stimulation by PHA. This is shown by the numerous "spikes" when lymphocyte function returned to normal. This patient experienced many rejection episodes and

expired due to rejection of the transplanted heart. Patient 11 showed prolonged suppression of lymphocyte function, experienced fewer rejection episodes, but expired due to infection.

TABLE 1
INFECTIONS FOLLOWING CARDIAC TRANSPLANTATION

Transplant Number	Infection	Etiology	Treatment	Results	Survival
1	Pneumonia vs. Infarction Groin Wound	Pseudomonas vs. Cytomegalovirus Pseudomonas & Serratia	Polymyxin, APHP* Gentamicin, G.G.†	Cleared Cleared	6 $\frac{2}{3}$ months
2	Stomatitis Pneumonia	Candida Albicans E. Coli & Enterobacter	Nystatin Methicillin	Cleared Expired	3 days
3	Pyelonephritis Pneumonia	Pseudomonas Pseudomonas	Polymyxin, Gentamicin, APHP,* G.G.†	Expired	8 days
6	Herpes Facialis, Stomatitis & Progenitalis Pneumonia	Herpes Simplex	Idoxuridine (Topical)	Cleared	5 months
7		Proteus, Serratia, E. Coli	Kanamycin, Colistimethate, Cloxacillin, Cephaloridine, G.G.†	Cleared	8 $\frac{3}{4}$ months
8	Prostatitis Perirectal Abscess Meningitis, Septicemia	E. Coli, Proteus Pseudomonas	Nitrofurantoin, Colistimethate Kanamycin	Cleared Controlled	5 $\frac{1}{2}$ months
9	Groin Wound Septicemia	Serratia Serratia	Kanamycin Gentamicin	Controlled (?) Controlled (?)	2 months
11	Herpes Facialis Pneumonia & Empyema Herpes—Stomatitis & Facialis	Herpes Simplex Pseudomonas	Idoxuridine (Topical) Kanamycin, Ampicillin, Colistimethate	Cleared Expired	2 $\frac{1}{4}$ months
13	Sinusitis & Nasal Cellulitis	Herpes Simplex	Idoxuridine (Topical)	Controlled (?)	
15	Pneumonia	Pseudomonas	Colistimethate, Gentamicin, & Carbenicillin	Controlled	4 months
16	Pneumonia vs. Infarction	Serratia	Kanamycin, Gentamicin, Ampicillin & G.G.†		1 $\frac{3}{4}$ months
		Serratia (?)	Chloramphenicol	Cleared	Present

* Antipseudomonas human plasma

† Gamma Globulin

‡ Infection primary cause of death

outcome in our first 16 transplants are summarized in Table 1.

Summary and Conclusions

The major obstacle to transplantation is the rejection reaction. Attempts have been made to avoid it by matching donor and recipient as closely as possible. These attempts have not been completely successful; therefore, methods of suppressing the reaction have been used. These consist of drugs, mainly corticosteroids and azathioprine, radiation, lymphocyte depletion and antilymphocyte globulin. Cardiac transplant patients are basically subjected to the same hazards as other transplant patients. Infection remains one of these hazards. Gram-negative organisms, herpes simplex and Candida infections were most frequent in the Texas Heart Institute series. Experimental lymphocyte function

tests using phytohemagglutinin have shown no diagnostic findings but appear to indicate those patients more subject to rejection as well as those more subject to infection.

Baylor College of Medicine

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TWELFTH ANNUAL

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This clinical study of the treatment of 42 children has yielded generally favorable results.

Dicloxacillin in the Treatment of Pure Staphylococcal and of Mixed Staphylococcal-Streptococcal Infections of Childhood

SANFORD J. MATTHEWS, M.D., Atlanta

DICLOXACILLIN, the 2,6-dichlorophenyl analog of oxacillin, produces higher blood levels than either of the other two isoxazolyl penicillins (oxacillin and cloxacillin),¹⁻⁴ and this makes it probably the most useful of the penicillinase-resistant penicillins available in oral form. The present report summarizes the results of its use over a period of one year (1967) in my office in the treatment of pure staphylococcal and of mixed staphylococcal-streptococcal infections.

Materials and Method

Specifically, the series consisted only of young patients (infancy through childhood) who presented

with infections produced by the coagulase-positive *Staphylococcus aureus*, alone or in conjunction with β -hemolytic streptococci, Group A (*Streptococcus pyogenes*). Included were 13 patients with impetigo contagiosa, eight with other *S. aureus* infections, 16 with pharyngitis due to streptococci in association with staphylococci, and five with other infections in which both organisms were found. For a more detailed listing of age, sex, and therapeutic status prior to dicloxacillin treatment, see Table I.

Each patient underwent a careful bacteriologic screening for susceptible microorganisms. Treatment was started with dicloxacillin whenever the infection appeared clinically responsive to it, but was

TABLE I
CHARACTERISTICS OF PATIENTS BY DIAGNOSTIC GROUP

Group	No. Pts.	Sex		<1	Age, Yr.			Ill Before Treatment, Days (mean)	Prior Therapy
		M	F		1-5	6-12	>12		
I. Impetigo ^a	13	9	4	5	3	5	—	5	2 ^b
II. Other <i>S. aureus</i> infections	8	4	4	2	3	2	1	4	1 ^c
III. Pharyngitis ^d	16	8	8	—	6	10	—	2	1 ^e
IV. Other infections by both <i>S. aureus</i> and <i>Str. pyogenes</i> .	5	3	2	—	2	2	1	3	1 ^b
Totals	42	24	18	7	14	19	2	3	5

^a All due to *S. aureus*.
^b Antibiotic ointments.
^c Oral penicillin V.
^d All were mixed infections due to *Str. pyogenes* and *S. aureus*.
^e Tetracyclines.

changed when patients were next seen (at the end of three to five days) if the bacteriologic data so warranted. In the case of β -hemolytic streptococcal infections, treatment was continued for the recommended 10-day minimum. The bacterial cultures were repeated two or three days after the end of treatment. Urinalysis, hematocrit, and leukocyte and differential counts were done before and after treatment. Other laboratory tests (including tests of liver function) were performed as indicated, but not routinely.

Specimens were taken from the skin, the lesions, or the nose and throat for culturing and sensitivity testing.* A blood agar plate assay was used to identify staphylococci and streptococci (α - and β -hemolytic).

As shown in Table II, 31 of the patients received dicloxacillin† in the form of a suspension, administered three or four times a day, one to two hours before meals; the mean daily dose (MDD) was 27 mg. per kg. per day (range, 13 to 75) and the mean period of treatment was eight days (range, five to 11). The remainder of the patients (11) received the agent as 125 or 250 mg. capsules; for these dosage forms the respective MDD's were 17 and 18 mg. per kg. per day and the respective periods of treatment were seven and six days.

Results

The clinical response is also shown in Table II. As indicated there, only two infections failed to respond to dicloxacillin and only three others were not fully

"cured" (i.e., did not return to full normality, with no further signs and symptoms of infection). Thus, 95 per cent of the infections can be regarded as responding satisfactorily to this treatment, and 88 per cent were in complete remission by the time it was concluded. The two therapeutic "failures" were so classified because other measures were needed to induce a satisfactory clinical remission: in the one case, incision and drainage, and in the other, intramuscular penicillin to suppress an earache that lingered on after other symptoms of pharyngitis had subsided.

All infections due to pure cultures of *S. aureus* responded to treatment with dicloxacillin; all microorganisms were eliminated except three found in the nares. All *Str. pyogenes* were eliminated. Twelve strains of *S. aureus* found in association with *Str. pyogenes* persisted beyond treatment, but of these, nine were found only in the nares.

Mild diarrhea or an increase in loose bowel movements occurred in seven patients. These reactions were transient; none required any change in the regimen. All laboratory data were within normal limits.

Discussion and Conclusions

Although 31 of the 42 *S. aureus* isolates were resistant to penicillin G and thus, presumably, penicillinase producers, all except three were susceptible to dicloxacillin, both *in vitro* and *in vivo*. The 12 that persisted in the nares after elimination elsewhere were apparently nonpathogenic, a finding not inconsistent with those reported by other observers.⁵

The staphylococcus may be gradually losing its ability to cope with antibiotics.⁶ As long as it retains any measure of its remarkable capacity to sur-

TABLE II
DICLOXACILLIN: MEAN DAILY DOSAGE (MG. PER KG. PER DAY)
AND CLINICAL RESPONSE

Group	Suspension		125 mg. Capsules		250 mg. Capsules		Clinical Response		
	No.	MDD	No.	MDD	No.	MDD	Cured	Improved	Un-improved
I	7	35	6	17	—	—	13	—	—
II	6	24	—	—	2	18	7	—	1 ^a
III	15	26	1	15	—	—	12	3 ^b	1 ^c
IV	3	24	1	19	1	19	5	—	—
Totals	31	27	8	17	3	18	37	3	2

* Infected eczema in a 3-month-old girl, caused by penicillin-resistant *S. aureus* which was not eliminated until the lesion was incised and drained.

^b All three were patients with pharyngitis. Two required intramuscular penicillin; in the third, the slow response was probably due to the presence of a mass of tonsillar tissue.

^c Pharyngitis cleared in 8 days, with elimination of responsible penicillin-sensitive *S. aureus* and bacitracin-sensitive *Str. pyogenes*, but earache remained until after administration of intramuscular penicillin.

DICLOXACILLIN / Matthews

vive by genetic alteration, however, we must not relax our search for new agents to use against it.

Among the orally effective agents presently available for combating the penicillinase-producing strains, dicloxacillin is perhaps the most reliable. Its efficacy in treatment of all mild to moderate staphylococcal infections appears to be established. To discourage the emergence of dicloxacillin-resistant variants, however, its use should be restricted to penicillinase-producing staphylococci.

Summary

Dicloxacillin was used to treat 42 children who presented during 1967 with infections due to *Staphylococcus aureus* or to *Streptococcus pyogenes* in association with this microorganism. These infections included 13 cases of impetigo, eight other skin, subcutaneous tissue or wound infections ascribable to *S. aureus* alone, 16 cases of streptococcal pharyngitis complicated by *S. aureus*, and five other infections in which both organisms were present. The patients received dicloxacillin either as a suspension (62.5 mg. per 5 ml.) or as 125 or 250 mg. capsules; the mean daily dose was 24 mg. per kg. per day and the mean period of treatment was eight days. Most strains of *S. aureus* were resistant to

penicillin G. All but three of the 42 *S. aureus* isolates were eliminated from cultures (excluding 12 that persisted in the nares). Of the 42 infections, 40 responded satisfactorily. Seven patients had loose stools. All present evidence suggests that dicloxacillin is an effective weapon against penicillinase-producing staphylococci, and it should be reserved for use against this type of microorganism.

1938 Peachtree Road, N.W.

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CALENDAR OF MEETINGS

In Georgia

- Feb. 8-10—American Society for Aesthetic Plastic Surgery, Marriott Motor Hotel, Atlanta
- Feb. 14-15—12th Annual MAG County Society Officers' Conference, Sheraton Biltmore Hotel, Atlanta
- March 8-10—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta
- March 15-19—Society of Toxicology, Marriott Motor Hotel, Atlanta

In the Nation

- Jan. 31-Feb. 1—Midwinter Radiological Conference, International Hotel, Los Angeles, Calif.
- Feb. 1-3—Residency Review Committee in Internal Medicine, Ramada Inn, Tucson, Ariz.
- Feb. 7—Society of Teachers of Family Medicine, Palmer House, Chicago, Ill.
- Feb. 7-8—Council on Medical Service, Drake Hotel, Chicago, Ill.
- Feb. 7-14—College of American Pathologists, Shamrock Hilton, Houston, Tex.
- Feb. 8-9—Annual Congress on Medical Education, Palmer House, Chicago, Ill.
- Feb. 14-17—Joint Committee on Health Problems in Education of the National Education Association

and the American Medical Association, Washington, D.C.

- Feb. 14-18—American Academy of Allergy, Jung Hotel, New Orleans, La.
- Feb. 15—Committee on Alcoholism and Drug Dependence, Washington, D.C.
- Feb. 20-22—Symposium on Rheumatic Diseases, Kachina Lodge, Taos, N.M.
- Feb. 25-March 1—American College of Cardiology, Rivergate, New Orleans, La.
- Feb. 27-March 1—AMA-AMPAC Public Affairs Workshop, Sheraton-Park Hotel, Washington, D.C.
- March 6-8—Committee on Nursing with its Panel of Nurse Consultants, Ponte Vedra Club, Ponte Vedra, Fla.
- March 8-10—American Association of Pathologists and Bacteriologists, Chase-Park Plaza Hotel, St. Louis, Mo.
- March 12—Council on Mental Health, Drake Hotel, Chicago, Ill.
- March 12-14—Southern Society of Anesthesiologists, Williamsburg Lodge, Williamsburg, Va.
- March 13-15—Council on Legislative Activities, Washington, D.C.

Richard Dennis Arnold
Savannah Physician and Unionist in the Years of Crisis
1832-1861

STEVE GURR, *Americus*

GEORGIA'S ANTEBELLUM social and intellectual life provides a view generally accurate for the other slave-holding states of the period. As the last of the original 13 colonies and the first of the lower South states, Georgia stood middle ground between the time-honored traditionalism of the Old Dominion and the newbreed rough and tumble of frontier Mississippi. Virginia had provided Georgia with some of her greatest leaders and Georgia continued the line, unbroken, into the new Gulf states of the west. From old areas such as Savannah and Augusta to more recently opened southwestern counties, Georgia's population and society exhibited a stratification typical in the antebellum South; planter to plain folk, poor white to slave. She produced national political leaders, plentiful crops and political crises commensurate with other Southern states.¹

At peace with the national leadership until the defeat of her own William H. Crawford in the 1824 presidential election, Georgia turned from Jackson and sent many of her best to Washington under the Whig banner. Torn by the sectional crisis of the 1830's and 1840's, she nonetheless took important steps to help preserve the union with her Georgia Platform in 1850. Her prosperity held the bonds of union until abolition, the Browns (both Governor Joseph and Abolitionist John) and Abe Lincoln made the nation suddenly divisible. Even as she called a convention to decide her posture she demonstrated a moderation suggesting anything but a single-minded pro-secession attitude within the leadership of the state.²

The Cobbs, Governor Brown, Alexander Stephens, Robert Toombs and others of national significance took major roles in the period of Georgia's

progress toward disunion. Each of these men provided leadership within the state and has been studied extensively for his specific contributions to the developments of secession and its eventual adoption in January, 1861. Lesser men were as deeply interested but are lost to the prominence of these national and state leaders. Their impressions of the institutions of slavery, nullification, abolitionists, and all the other paraphernalia of the sectional confrontation are worthy of attention.

Physicians Leading Citizens

Georgia could count some of her leading citizens within the medical profession. Several Georgia doctors of the period were unusually active beyond their professional roles. Francis Orray Ticknor, besides being a leading Muscogee County physician, was a poet of the war years who has been favorably compared with Henry Timrod.³ William Bacon Stevens compiled an illustrious record of social, intellectual, and cultural contributions to the state. After his medical studies he helped to found the state historical society, served as a missionary of the Episcopal Church to Athens and as author of an important history of Georgia.⁴ Dr. Ambrose Barber moved to Macon in the early 1820's and until he died in the 1840's was active in the Episcopal Church, military ventures, public education, and public health. His interests included middle Georgia's economic development which involved him in business throughout the state. In 1841 Barber was made Charge d'Affairs to Sardinia.⁵

Richard Dennis Arnold was a leading Savannah physician from 1832 until 1876. He was also an educator, politician, gentleman and a Georgian vi-

tally interested in the events around him. He wrote extensively to friends both in Georgia and in the North where he had been educated and where he had professional ties. His contacts were with men of medicine, business associates, political figures and his daughter, who was in school in Philadelphia during the period. The variety of his correspondence provides a view of the man from several angles. His letters to Unitarian clergymen reveal attitudes toward slavery, abolition and God; those to a Democratic newspaperman friend in Philadelphia show Arnold as a politician. Letters to fellow physicians refer to money, medicine, the need for better professional education, fevers, and professional journals. The letters to Ellen Arnold, his daughter, show all these as well as the more personal views.

Taken together, the letters of Dr. Arnold reveal a Southern dilemma, the dilemma of conscience and realities in antebellum Georgia. Lost amid the larger figures of his time, Arnold's insights provide yet another view of leadership in the antebellum South in the years of crisis and defense.

Mayor of Savannah

Dr. Arnold began his practice in 1832 and was active in the Savannah community for 44 years. During that time he served in the state legislature and as mayor of Savannah. He was delegate to National Democratic Conventions, president of the Board of Education, a founding member of the Georgia Historical Society, secretary and later vice-president of the American Medical Association. In the early 1830's he was part owner and editor of the *Savannah Georgian*.⁶ That Dr. Arnold should enter Georgia society and politics in the year of the nullification controversy and end his involvement in the year of post Civil War reconciliation makes him all the more helpful in a study of Georgia history during the nineteenth century.

As sectionalism emerged in the 20's and 30's, several component issues came to the surface and served as topics for debate in both North and South. Slavery, the Negro and abolition were frequent topics of Arnold's correspondence. In a letter to a former Savannah Unitarian clergyman, then in Boston, Dr. Arnold early defined his views of the abolitionist. He professed a respect for the North but indicated fear of continued agitation from the abolitionists. Here, in 1838, he predicted that such agitation might destroy the Union.⁷

Such observations were typical, but when they are matched with Arnold's view of the Negro they take on meaning. As legal guardian for a number of free Negroes in Savannah, Arnold expressed the hope

that the rights of his charges would be respected and protected. This concern was coupled with Dr. Arnold's interest in the preservation of the family unit among the slaves. He was sometimes called upon to dispose of property, including slaves, in the settlement of estates and when possible he avoided breaking up the slave families.⁸

Racist Views

In letters to his daughter he described the goings-on among the house servants in paternalistic phrases and in his correspondence with medical colleagues he voiced the prevailing physiological racist views. As a physician Arnold's racism had practical as well as moral value. In a letter to Dr. A. P. Merrill in Memphis in 1854 he stated that Negroes were less liable to suffer malarial diseases than whites.⁹

Although he seems to have had genuine concern for the welfare of the Negro and though he apparently saw the philosophical contradictions of the institution of slavery, admitting it was indefensible from the view of abstract rights,¹⁰ he faced the social and economic implications and defended the system as impossible to destroy without serious effect on the foundations of Southern society.¹¹ His position as a doctor gave Arnold a peculiar view of slavery. As abolition activity increased he found logic for slavery in his medical practice. In an 1849 letter he said that he wished the abolitionists could see the medical care given the Negro. In a not-unfamiliar argument he suggested that humanity and financial interest went hand in hand in the South to the benefit of the Negro, while where slavery was white and called by another name even incidental humanity was absent.¹²

Far from losing himself in the political and social implications of slavery and abolition, Dr. Arnold continued his active practice and busied himself with professional concerns. He wrote his colleagues in the North that the physician's lot in the South was a favorable one in some respects, yet discouraging in others. Slavery provided the doctor with the important task of keeping the planter's investment in working order, but Dr. Arnold feared that the pace of work and the isolation of the South from the centers of medical education detracted from the physician's professional opportunities.¹³

Profitable Practice

Arnold's practice was, after the first lean years, an active and profitable one. Although he sometimes complained of his financial condition, during the 1840's his accounts show an income for one month of twenty-five hundred dollars.¹⁴

The medical profession not only provided Dr. Arnold a considerable income, it was also a source

of pride and constant work for him. Beyond the great efforts he made during the yellow fever epidemics of 1852 and 1858, Arnold was involved in the organization of the profession at the state and national levels. In 1846 he was a delegate to the national medical convention in New York at which he and others drew up plans for the American Medical Association.¹⁵

Dr. Arnold often referred to the state's medical education facilities in his letters. He and several Savannah colleagues formed a medical school in 1853, the Savannah Medical College, and Arnold himself was Professor of Theory and Practice of Medicine. Despite these efforts Arnold was not satisfied with medical training in the state, going so far in the 1860's as to accuse other colleges of lacking principle in their professional training.¹⁶

Frequent Traveling

Professional meetings frequently took Dr. Arnold to New York and Philadelphia and his letters from these meetings testify to yet another interest. Writing to his wife he often described in detail the elegant dinners and social customs of the North. He was considered something of an expert on wines and their treatment and these letters pay careful attention to these potables.¹⁷

The social interests of Dr. Arnold and his prominence in the Savannah community led naturally to his involvement in cultural developments in the city. In 1839 Arnold, along with Israel K. Teff and William Bacon Stevens, laid plans for the establishment of the Georgia Historical Society. The Society was a source of pride and interest for Dr. Arnold until the end of his career.¹⁸

Social, cultural, professional and political interests did not exempt the doctor from family concerns that reflect the social climate of the age. In a letter to his daughter in 1851 he reprimanded the 17-year-old for excessive dancing and keeping late hours.¹⁹

Political Struggle

The political era of Richard Arnold was hyperactive in Georgia and the nation. The Savannah doctor was a part of the same struggle in politics that embroiled the more famous Joe E. Brown, Alexander Stephens, Robert Toombs and other nationally important figures. Dr. Arnold's baptism in Georgia politics came three years after his return to Savannah. On July 4, 1835, Arnold delivered an address to the Union and State Rights Association of Chatham County. The speech was filled with flag waving but the young doctor soon turned to the current political scene. He attributed to John C. Calhoun an affinity for the Articles of Confederation rather than the Constitution and declared the

national compact of the Constitution to be sacred beyond individual state alternatives.²⁰ The speech marked Arnold as a Union man, a position still defensible in Georgia in the mid-thirties. The path from the 1830's proved winding and few followed without taking new direction. Arnold attempted to do so.

Party battle held fascination for him and yet he often protested that politics was a dirty game in which all parties were guilty of low tactics, fraud and corruption. Later, only shortly after the death of his wife, Dr. Arnold's daughter came home to Savannah to find her father in the midst of party battles. In his apology for involvement, he offered as his excuse his desire to preserve the Union.²¹ Apparently his concern was genuine. The year 1850 was a most significant one for the fate of the Union and that year Arnold took stands less popular than they might have been in the 1830's.

In a letter to his friend, John W. Forney, a Democratic journalist in Philadelphia, Dr. Arnold discussed Georgia and the Clay Compromise. As a supporter of the Compromise, Arnold faced considerable opposition among fellow Georgians and especially disappointing for him, among fellow Democrats in the state. He felt that the "fire-eaters" among the Democrats would attempt to consume the state party, and he took an open stand against such possibilities. It was possible, he believed, to preserve both Union and Southern rights. Dr. Arnold saw other state Democrats as secessionists in state's rights clothing bent on "doing in" those like himself and John E. Ward who still saw the possibility of union and rights. He asked Democrats in the North to wait and see if the Union party, strong with Whigs and Democrats, might not save Georgia from the "fire-eaters."²²

Expressed Faith

Six months later in another letter to Forney, Arnold expressed his continued faith in the national Democratic Party as the safest repository of state rights and union. Reassuring his friend of his own political consistency, Dr. Arnold wrote in September, 1851 that by looking in old copies of the *Savannah Georgian* in the years he owned and edited that newspaper, he could see that his views were the same almost two decades later. He said that if the word secession was substituted for the word nullification, the editorials he wrote in the early 1830's would serve useful purposes in the 1850's. Hedging a bit perhaps, he added that there was a danger to the Union and that though a Union man, he was also a true Southerner. As such, he genuinely believed in that portion of the Georgia Platform which

based the state's support of Clay's Compromise on relief from further northern aggression.²³

Five years later, following Buchanan's election as President, Arnold again wrote Forney, expressing the hope that a good Georgian, Howell Cobb or John E. Ward, would be chosen for a post in the new cabinet. This hope was fulfilled when Cobb was appointed Secretary of the Treasury. Arnold considered Buchanan the man who could preserve the Union. Five months later a note of bitterness was apparent in a letter to his brother-in-law in which Arnold complained of spending freely for the Party, serving as a stalking horse all his life and failing to reap any benefit for himself.²⁴

The Buchanan election marked the high tide of Arnold's strong unionism. Disappointment and bitterness deepened, with Arnold accusing Forney and those of similar political leanings of driving the South to desperation. But as Forney joined other Northern Democrats in support of Stephen A. Douglas and deserted James Buchanan for his support of the Lecompton Constitution in Kansas, Arnold lamented the death of the National Democratic Party.²⁵

Bleak Times

The late '50's were bleak for Union Democrats, but Dr. Arnold found time in late 1858 to write Secretary of the Treasury Cobb concerning some wine he was sending to Washington. He took care to describe the proper treatment and to instruct Cobb in the proper serving of the Madeira. Politics had not yet destroyed the doctor's diversity of interests.²⁶

The summer before Lincoln's election Dr. Arnold traveled to New York and Boston. In writing home his observations of life and sights in the North, political expressions crept into almost every letter. By the end of the summer he had declared that the North was hostile to Southerners. He saw in the North meddling and threat, and he wanted no alliance with that section. He saw inevitable conflict, and he hoped that it would be resolved soon and not continue, prolonged, for years to come.²⁷

Arnold's last letters before Georgia's secession were to the North and friends there. Following the election of Lincoln and before South Carolina had taken action, Arnold wrote that feelings in Savannah were quiet but deep. Republican victory was equated with radical takeover, and Arnold expressed the view that continued hope for reconciliation with the North was useless. The North refused Southerners the sin of slavery, yet the states which had elected Lincoln treated the Negro as politically

inferior. Northern inconsistency struck deep at Arnold's union sentiments.²⁸

Verge of a Decision

As Arnold wrote in December, 1860, Georgia was on the verge of deciding her future in relation to the Union. Governor Brown, Howell Cobb, and Robert Toombs spoke for secession; a few, including Herschel V. Johnson and Alexander Stephens, called for moderation and delay. Richard Arnold stood at a crossroads. Since his speech to the Union and State Rights Association in 1835 he had professed support for the Union. He defended the Union Democrats against "fire-eaters" and extolled the value of the Union and Clay's Compromise in 1850. Ten years later he chose a new path. On December 28, 1860 Dr. Arnold abandoned his long defended stand and conceded that the Southern states should withdraw from their compact with the North. He recognized the difficulties of such a break and predicted that violence would accompany the action. He claimed for the South a defensive position in which submission no longer had a place.²⁹

Five days before the signing of Georgia's Secession Ordinance, Dr. Arnold wrote a brief note to an acquaintance in Philadelphia. The letter contained four sentences. The first two concerned collection of a debt for his friend, the other two stated that Georgia was leaving the Union and called for God's help in her cause.³⁰

511 Oak Avenue

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Heart Rate Measurements of Drivers With the Highway Systems Research Car

FLETCHER N. PLATT, *Ann Arbor, Mich.*

ONE OF THE MOST PRESSING NEEDS in traffic safety is the development of quantitative means of measuring driver performance.

Subjective ratings have provided the principal means of comparing drivers, although they are quite inadequate as statistically reliable guides. Accident and violation records are generally used as measures for licensing and insurance purposes, but the prediction of a driver's future performance based on past experience is not always meaningful. Chance plays some role in the probability of a driver being involved in a traffic accident, but the odds vary with factors of time, location and environment.

During the past 12 years, instrumentation has been under development by Ford Motor Company to fill the need for measuring driver performance and its relation to all other parts of the system: the vehicle, the highway, the traffic and the environment.

The latest versions of the equipment, installed in a Mercury Marquis, have been described in several papers.^{1, 2} The first Highway Systems Research (SR) Car (1965), measured movement of the controls, time of trip, speed and acceleration. The unit was called a drivometer, developed by Dr. Bruce D. Greenshields of the University of Michigan. The next year new sensors were added that provided measurements of driver stress. It was believed that measures of driver stress would be valuable in the evaluation of driver performance by providing insight into the inter-relationship of emotion and skill and how they affect driver control movements, driver errors and probability of acci-

dents. After a number of exploratory (clinical) research projects, it now appears that heart rate measurement will play an important role in evaluating drivers under normal, degraded and augmented conditions.

History of the Equipment

About five years ago, Philco-Ford (WDL Division) developed an electronic system for measuring several physiological parameters of the Apollo astronauts, without having to attach sensors. This development led to the design of a medical monitoring chair, which used an analog recorder to pick up heart rate, blood pressure wave, respiration rate, stethophonic waves and galvanic skin response.

Discussions with WDL's biomedical staff* were held regarding the possibilities of installing all or part of the medical monitoring chair in the instrumented car. For a number of reasons, primarily because of the space and cost required for both analog and digital recorders, it was decided that heart rate and GSR (in digital format) could provide acceptable measurements of the driver for stress evaluation. The steering wheel was suggested as the best possible sensor contact. After some testing, a gold-plated wheel was found to give the best signal-to-noise ratio. (It also proved to be the center of attraction at demonstrations.) Electronically, the heartbeat electrical signal of the "R" wave is picked up through the circuit formed by both hands on the steering wheel, on either side of insulators located at 12 o'clock and 6 o'clock on the wheel. The signal is electronically amplified through several stages. Electrodes can be attached to the driver if a con-

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** Dr. DePaul J. Corkhill, Dr. M. E. Fitzwater, Mr. M. E. Lapidès and Mr. Earl L. Jackson.*

tinuous signal is required. However, the data reduction program is designed to print out the time the heartbeat is not recorded and this is listed as a percentage of one hand driving. (A galvanic skin response (GSR) can also be picked up through electrodes to the driver's ankle or foot.)

TABLE I
RANK ORDER RELIABILITY COEFFICIENTS OF PATTERNS OF SOMATIC REACTION TO STRESS

Physiologic Variables Compared	Rho	Confidence Level
Systolic Blood Pressure vs. Heart Rate .....	.91	.01
Palmer Conductance (GSR) vs. Heart Rate .....	.88	.01

Heart Rate Research of Others

Since 1950, there has been an increasing amount of research reported on the measurement and interpretation of heart rate related to psychological stress. Lacey³ listed a rank order of reliability coefficients of patterns of somatic reaction to stress (Table I). Systolic blood pressure versus heart rate had the maximum P and .01 confidence level. Lacey and several other authors, in a book on psychophysiological research (1963), wrote a chapter on "The Visceral Level: Situational Determinants and Behavioral Correlates of Autonomic Response Patterns."⁴ Figure I shows a chart of response curves for heart rate and palmar conductance (GSR) for two groups of subjects under eight different stimulus conditions. It is of interest to note that heart rate does not always increase with the stimulus, when preceded by an alert. The summary specific-

ly discusses the meaning of heart rate acceleration and deceleration in addition to mean heart rate under different types of stimuli. However, the following quotations may serve to indicate the "state of the art" in 1963.

"The studies reviewed so far have shown, in different ways, that palmar conductance and heart rate responses have different behavioral significance, and respond differently in different stimulus conditions.

"This brings us full circle to the clear realization that concepts currently invoked to relate autonomic activity to behavior are inadequate."

Wood and Obrist (1964) have demonstrated that the initial acceleratory components of the biphasic response is a respiratory artifact which leaves only deceleration as a possible conditioned response.⁵ Tests were also made to study "The effects of UCS Intensity, Vagal Blockage and Adrenergic Block of Vasomotor Activity." The results were inconclusive.

In 1965, Obrist and two other authors described a study on "Heart Rate During Conditioning in Humans."⁶ A quote from the introduction should be noted:

"When a noxious UCS is used, such responses are reported to be either a deceleration of heart rate, or a biphasic response characterized by an initial acceleration followed by the usually more sustained deceleration."

Tests by Uno and Grings in 1965⁷ using five intensity levels of sound showed heart rate changes were primarily monophasic and did not exhibit a consistent deceleration or acceleration pattern.

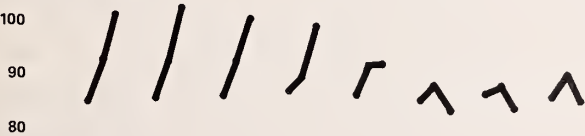
In summary, it appears that in most cases heart rate *change* (acceleration and deceleration) is a general indication of autonomic response to stimuli. The mean heart rate itself may increase, decrease or stay constant over a series of stimuli such as those encountered in the driving task, but the deviation from the mean and range (lowest and highest rates) may prove to be significant when differentiating between conditions or between drivers.

Applied Research of Others

STUDENT PILOTS: Heart rates of student pilots were measured by C. E. Melton⁸ during dual and solo flights and check rides. Differences between group means (Fig. II) are all significant at least to the 5 per cent level, with means of dual and check flights differing at the 1 per cent level of significance. Average heart rate increased as a straight line during dual training from 85 beats per minute before the first flight to 110 by the sixth lesson. It then leveled out at 110 beats per minute

MEAN RESPONSE FOR EIGHT STIMULI

HEART RATE /MIN.



GSR SIGNAL

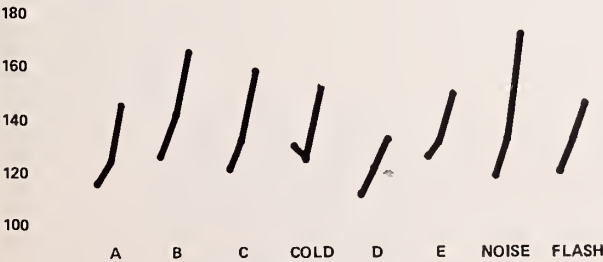
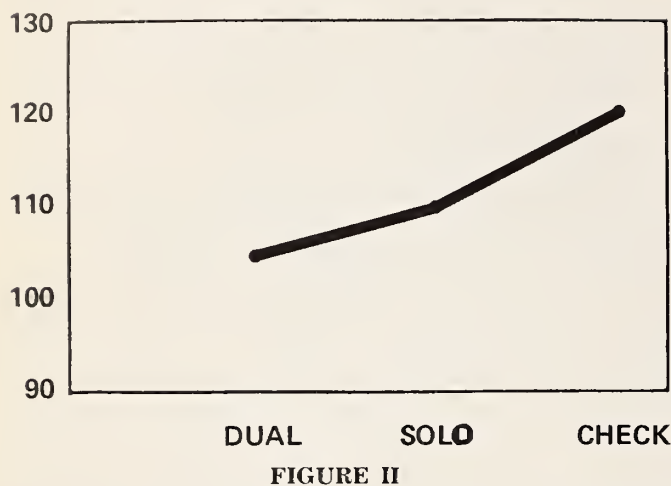


FIGURE I

STUDENT PILOTS

HEART
RATE

during subsequent flights. Short field takeoffs and landings showed significant increases in group means—112 (96-137 range) for takeoff and 120 (99-161 range) for landing.

An interesting sidelight on this study showed that the number of eye movements did not prove to be relevant. Student eye movements were more frequent when the student was in control during dual flights and tended to be more frequent on cross-country flights than local flights. However, there did not appear to be any correlation between eye movements and the instructor's subjective score of the students.

MILITARY FLIGHT TEST TRANSPORT PILOTS: Risk and responsibility apparently play a role in the amount of stress imposed on a pilot as judged from heart rate. Roman's studies on pilots in a two-place F-104B aircraft clearly showed that a change from passenger to pilot duties was accompanied by a consistent increase in heart rate.⁹ The increase was greater in proportion to the demands of the mission. In another study of Navy carrier pilots, Roman, Older and Jones¹⁰ found that heart rates of experienced combat pilots flying A4's on missions over South Vietnam showed peak heart rates at launch and recovery *with the lowest values occurring during actual bombing runs*. Other studies by Roman have shown that the slot man of the USAF Thunderbirds had a heart rate higher than the average of the rest of the team (170 bpm vs. 139 bpm). High heart rates of pilots of the X-15 vehicle and the M-2 lifting body (170 and 188 bpm, respectively), as compared with pilots flying high-performance aircraft, are quoted by Roman.

Smith¹¹ reports that the heart rate of seven experienced transport pilots (BOAC) were recorded

at five second intervals during takeoff and landing and at five minute intervals during preflight checks, taxiing and the remainder of the flight. The rates of all pilots were raised during every takeoff and landing. It was also increased to a varying extent according to the difficulties and hazards of the remainder of the flying task. Rates increased 50 per cent above resting value during takeoffs and landings. The peaks occurred several seconds after the points of decision; in takeoff at critical loss of engine time and in landing when the decision to land had been made (Fig. III).

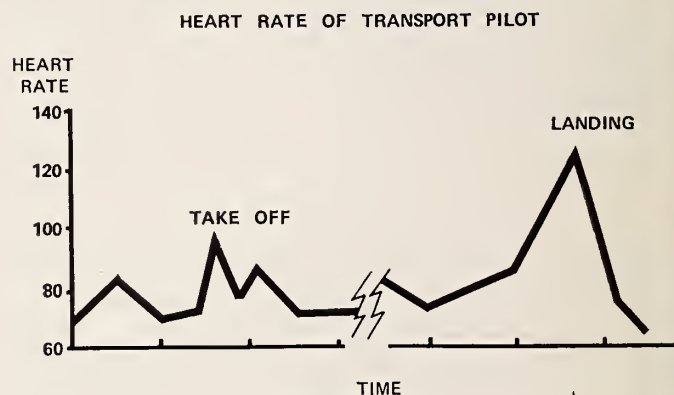


FIGURE III

Automobile Drivers

Dr. Simonson's work at the University of Minnesota has been outstanding, both in instrumentation development and fundamental knowledge obtained. His paper, "Cardio Vascular Stress Produced by Driving an Automobile"¹² describes some of these studies. His major interest was to determine the effect of driving stress on heart patients. (A grant for continuation of this work was cut off because the funding agency did not consider the research to be safety oriented.) The paper is an excellent review of the literature in Europe and the United States, in addition to the research conducted by Simonson and his staff. Excerpts from the introduction and summary are most significant.

"The type of physiological stress involved in driving is probably complex, and a comprehensive study involving recording of electroencephalogram (EEG), electrocardiogram (ECG), GSR, blood pressure, respiration and a vigilance test, together with performance of both vehicle and driver, has been initiated. It appears, even from preliminary results, that there is a significant cardiovascular involvement in the general stress of driving an automobile.

"The heart rate responds instantaneously to critical situations and in stressful situations such as car racing increases rapidly to frequencies of



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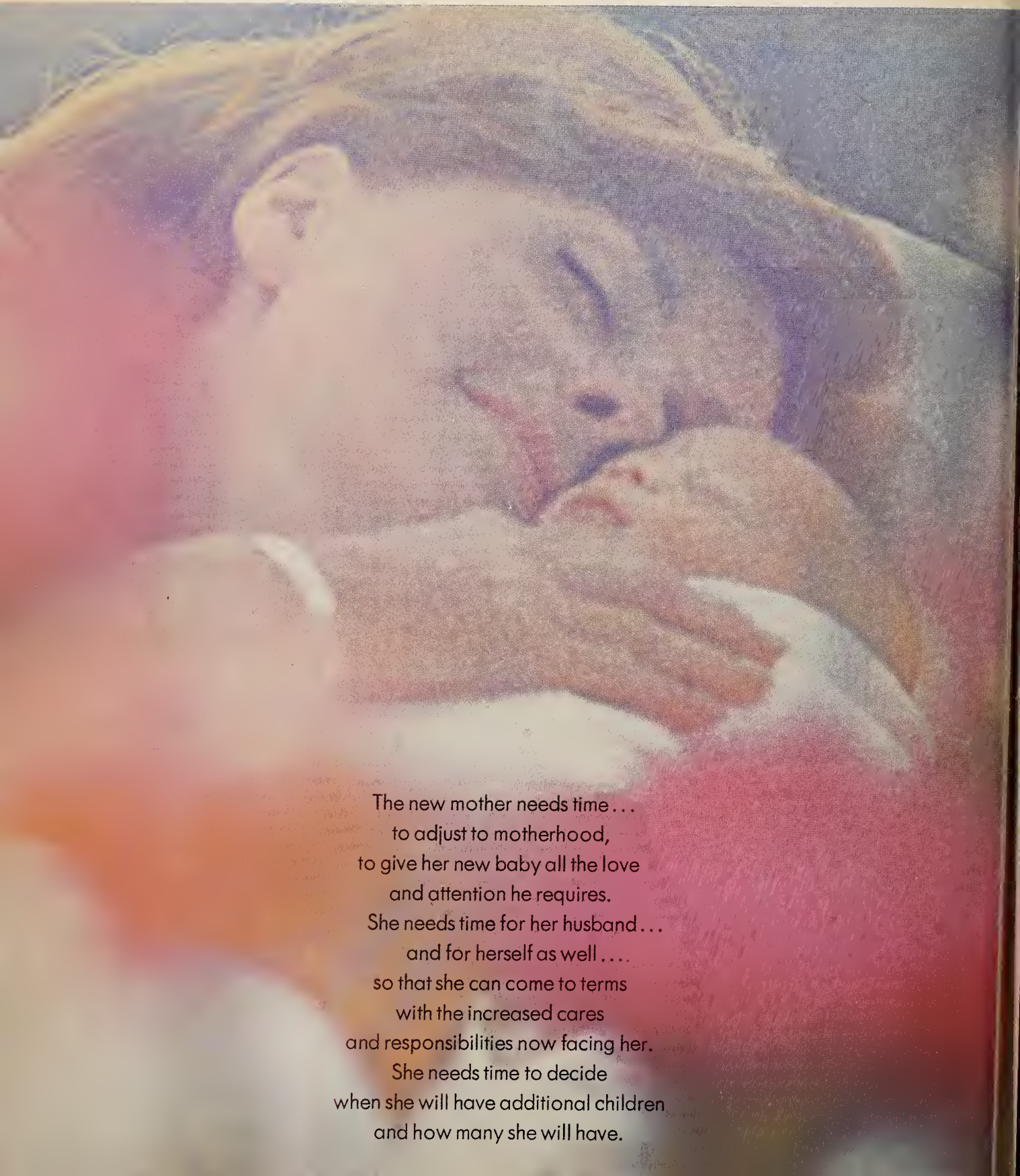
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A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968^{1,2} estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contra-

ceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestagen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes

in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T₃ uptake values; metyrapone test; pregnenolone determination.

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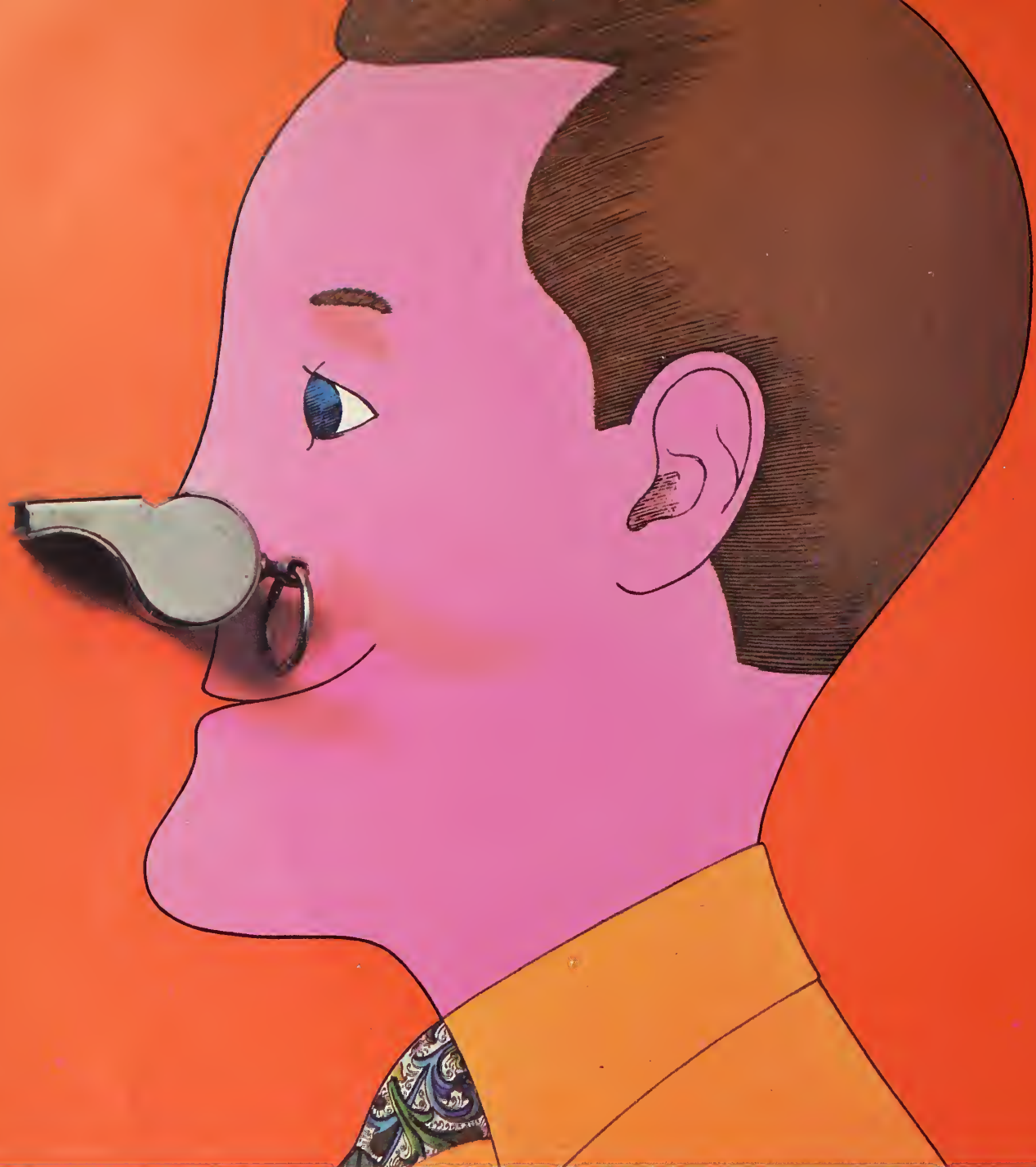
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200 per minute or more.¹³ Blood pressure is less responsive. Significant ST depression and T wave changes were reported in healthy drivers and more so in ambulatory patients with coronary heart disease or in hyperreactors.”

One important side note in Simonson’s work was the prediction, based on statistical analysis, that 1,000 heart attacks a year may be expected to occur in drivers in Minnesota. Extrapolated to be representative of the country, this could mean 50,000 drivers will be stricken (by heart attacks) this year in the United States.

Additional Excerpts

The following three sections also are from Simonson:

Drivers With Heart Disease

“In driving ‘without disturbance,’ none of the healthy drivers had an increase of the heart rate over 20 per cent of the resting rate, while this occurred in 21 of 32 drivers with ‘vegetative Labilitat.’¹⁴ In critical situations, increase of heart rate exceeding 20 per cent of the resting rate occurred in 39 per cent of healthy drivers and in 75 per cent of the patients.”

Driving on Long Trips

“In long distance driving (up to 16 hours) Suenaga, Goto and Torigoe¹⁵ found a general tendency to a decreased pulse rate from the initial values. The decrease was less pronounced when two drivers alternated instead of one driving continuously. They believe that the decrease of the heart rate is due to ‘fatigue,’ because there seemed to be some correlation with ‘feeling sleepy.’ There is, however, no evidence that fatigue decreases the pulse rate, while an increase of the pulse rate with fatigue has been observed in other types of work.”

Race Drivers

“While we are primarily interested in the effect of ordinary city and highway driving, Collins’ observations on racing-car drivers are of interest because car racing may show, in exaggerated degree, the physiological stress involved in driving an automobile. There is a steep increase of the telemetered pulse rate with the beginning of the race up to 170 to 200 beats per minute, or even more. It either maintains that level or drops slightly during the race with comparatively small fluctuations, followed by a precipitous drop after the race. These findings were corroborated by Taggart and Gibbons,¹⁶ who found in three drivers during competitive circuit racing an increase of the heart rate between 190 and 205.

The drivers were unaware of palpitation or any other symptoms. In all investigations with the heart rate determined from the ECG, the increase of heart rate was due to sinus tachycardia.”

HSR Car Medical Monitor

As described earlier, the HSR Car Medical Monitor has two electronic circuits, one for heart rate and the other for GSR. When the equipment was designed in 1965, it was not known whether one or both sensors would be needed to evaluate driver stress. GSR had been used in a number of driver behavior research projects but heart rate had been used in only a few. Because of the convenience of using the steering wheel for driver contact, and the apparent sensitiveness of heart rate to stress in early HSR tests, GSR was measured only in a few HSR projects.

The computer program was designed to give heart rate per minute for each time period and to compute the percentage of time the driver had only one hand on the wheel (or was holding the wheel very lightly). This was done by counting the time the beat-to-beat heart rate signal was more than two seconds (30 beats per minute).

The average heart rate is “cleaned up” by the computer program as the rate in any time frame is not averaged if the per cent of one hand off wheel is greater than 50 per cent. It has been found that drivers range from 5 per cent to 80 per cent hands off wheel with the norm in the 20 to 40 per cent range. Beginning drivers usually grip the wheel with two hands most of the time. However, for the chain smoker, even a 20 per cent heart rate sample appears to satisfactorily indicate stress changes.

Basis of Time Frame Selection (1/10 minute)

The computer program has been developed over a two-year period with a number of side studies made to evaluate various general data reduction methods and to select standards. The program was set up to give the researcher a choice of time for printout from signal input time (22.5 times per second), 1/100, 1/10 and 1 minute intervals. Heart rate was studied on a beat-to-beat interval as well as each of the time frames noted above. Physiologists have known that respiration affects heart rate (sinus arrhythmia) and is evident in the HSR data reduction. The heartbeat apparently responds to emotional changes within one or two beats of the stimulus and driving stimuli may occur as often as ten per minute. The 1/10 minute (six second) time frame seems to be most responsive to individual stress situations caused by the driving task and has been established as the standard for computer printout. It is interesting to note that the study of BOAC

transport pilots¹¹ used five second intervals on heartbeat rate.

The heart rate sensor and computer programming provides a number of related dependent variables:

1. Basic heart rate
 - Beat-to-beat
 - 1/10 minute
 - Subtotal average
 - Trip average
2. Standard deviation of heart rate for each trip
3. Range of heart rate—high and low for each trip
4. Per cent of time one hand off steering wheel
5. Relation of heart rate to control movements.

All of the above factors need more intensive study to determine their relationship to total driver performance, emotional characteristics, error rate and accident rate.

Standard Driving Test Procedure

The author has developed a standard test procedure that has been followed by most researchers using the HSR Car.

1. At rest heart rate—the driver is asked to hold wheel with both hands, relax and not talk. Heart rate is taken for one minute.
2. Standard route selection—a 20 to 30 minute route is selected in each locality to give approximately six minutes of driving in each of four different environments including urban arterials, residential, four-lane divided and rural (where possible).*
3. An induced stress test has been developed to measure the driver's performance with secondary task loading. The freeway section of the test route is divided into three parts:

On the first part, the driver is asked to drive normally and at a speed suitable to the traffic.

On the second part, the driver is asked to maintain a constant speed (of his choice), monitor the instrument panel clock every 30 seconds, and to respond to several questions. Questions include: spelling your last name backwards, naming seventh letter from end of alphabet, summing the digits from one to nine.

* Shorter routes can be used, but discrimination is less accurate. Longer trips are not recommended if inexperienced drivers are included in the sample. Because the first trial has proved to be the most discriminating, preliminary runs are not required.

On the third part, the driver is asked to relax and drive normally again in order to determine his recovery time.

4. After test heart rate—following completion of the test run the driver's heart rate is again tested at rest.

More than 100 subjects have been tested, and although correlation studies have not been made, drivers' heart rate usually increased five points or more under induced stress. It appears to take at least two minutes for most drivers to recover their normal heart rate. Highly skilled drivers may show little change in control movements while others have higher rates under stress, particularly steering reversal rates. In other words, *a driver may be affected emotionally by stress but it is important to know if his performance (error rate) is also affected.* Several drivers have shown no increase in these measurements, while others remain above norm for the remainder of the trip. Additional exploration of this method is suggested.

General Observations on Research to Date

During the past two years, a number of exploratory research projects have been conducted with the HSR Car by the author and others.¹⁷ In medical terms, most of these studies would be classed as clinical studies (without statistical validation). Nevertheless, certain findings have been observed in these studies that can lead the way for more definitive research, with larger samples, and improved experimental design.

The following observations are based on accumulated data.

1. Standard Test Runs—Gross Means

In order to get a large sample, five populations of drivers from five parts of the country were combined to get mean data. The total numbered 157 drivers and 218 separate test runs.

Mean Heart Rate 69.4 beats/min.

Standard Deviation Heart Rate 23.9

2. Standard Test Runs—Sample Data

Several sample runs were tabulated and the means of heart variables listed for two small populations as well as a table of the minimum and maximum values for these groups of drivers.

While driving, the mean heart rate for individual drivers was 53 bpm for the lowest and 100 bpm for the highest. Heart rate standard deviations were much higher when driving than when parked.

3. Passing on Two-Lane Rural Road

An interesting side study was made pos-

sible (in the South Dakota project) by marking the time when cars were passing the subject car in the opposite direction. Four passes are shown as examples of the effect on one driver. The heart rate of this driver was depressed at time of passing in each instance.

4. Warm-Up Time and Time of Day

The Iowa State study by Dr. Lauda demonstrated that time of day had an effect on heart rate over five trip replication. During the 7:00 and 9:00 a.m. trips, the heart rate was lower at the beginning of the first run than at the end of the fifth. The reverse was noted on the 5:00 p.m. trip. There was very little effect at 12:00 noon and 3:00 p.m.

GSR was also measured in this project as well as blood pressure measurements before and after each trip. These measures suggested additional research projects are necessary, but GSR was shown to be a meaningful variable.

5. Freeway Ramp Entry Study

Tests made in Texas showed that a driver's heart rate increased significantly during ramp entry to a freeway. The example shows a maximum heart rate of 115 bpm, however, one of the other drivers tested had a rate that reached 150 bpm during acceleration.

6. A Routine 1½-Hour Trip on an Interstate Route

A driver was tested during a 1½-hour drive on an interstate route in daylight with light traffic. Data was totalled in 10-minute intervals. The driver's heart rate dropped significantly during 20 to 50-minute period (from 80 to 64) and following the luncheon stop (from 72 to 57). Steering reversal rate increased from an average of 37 reversals/min. during the first 30 minutes to 61 reversals/min. during the last five minutes before lunch. Steering reversal rate went down to an average of 32 after lunch while per cent one hand off wheel tripled (12 to 36) after eating.

7. Secondary Task While Driving

Drivers were tested by Schuster at Iowa State on a standard route with and without a secondary task. All major variables increased somewhat and the discriminant analysis showed heart rate to have the highest rank order in discrimination.

8. A 12-Hour Trip on Turnpikes

A long trip was taken by two drivers from Dearborn to Philadelphia via Ohio and Pennsylvania Turnpikes. The drivers alternated

in 1½-hour intervals. After nine hours in the car and shortly after a stop for dinner, the data showed the driver was apparently falling asleep. The heart rate steadied and steering reversal rate dropped nearly to zero for more than a minute. The observer apparently was not fully aware of the seriousness of the situation but alerted the driver to an approaching tunnel when he did not start to slow down.

9. Driving Under Adverse Weather and Road Surface Conditions

A trip was started on the Pennsylvania Turnpike in the mountains near Somerset by the author. There was a strong wind with light blowing snow covering the pavement with an inch of powder. There were occasional glare ice patches under the snow and trucks and other cars were pulling off the road.

Although the speed was reduced to 47 mph, standard deviation heart rate was high and maximum heart rate reached 150 bpm. The mean steering reversal rate for 25 minutes of driving was 71 per minute with several minutes over 100 per minute. The driver's normal heart rate is 80-85 and steering reversal rate is 35-40.

10. Driver with Mild Sedatives

A driver was tested while driving home (on his usual route) with and without medication. The sedative was given as part of a routine medical examination approximately two hours before the drive. The driver was very sleepy during the first section of the run but felt normal by the end of the second section.

In addition to the difference in speed with medication (higher on the first section than on the second), standard deviation of heart rate (from 9 to 15) and maximum heart rate (from 94-110) showed considerable increases during the first section. During the second section of the trip, standard deviation of heart rate increased (from 15.2 to 17.5) and maximum heart rate (from 103 to 122).

11. Intoxication Tests

At Michigan State University, six drivers were tested on a closed obstacle course 0.6 mile long. Drivers' ages were all under 30. The first test was made while sober, the second at .10 per cent blood alcohol getting intoxicated and the third at .10 per cent while sobering up. Drivers showed less inhibitions while sobering up than while getting intoxicated as indicated by 20 per cent increase in

speed and higher control movement rates. Heart rate variables showed less differences, and were lower in rank than control movements in the discriminant analysis. Discrimination was 100 per cent between these populations.

This is an interim report of exploratory research with a new instrument. Emphasis has been given to heart rate evaluation, which has not been described in detail before. Other available reports describe specific projects completed to date.

It is hoped that this paper will intrigue others to explore the vast potential of HSR equipment for quantifying the many variables associated with the highway system, and particularly *Homo sapiens*, the unpredictable driver.

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Acknowledgement: Many of the references were provided by Mr. Jerry A. Emery, Human Factors Supervisor, Tactical Missile Systems Operation, Aeronutronic Division, Philco-Ford Corporation. He was kind enough to make his files available to the author. His assistance and advice is appreciated.

DRAMATIC WARNING ABOUT SMOKING FILMED FOR COMMUNITY GROUPS

An anti-smoking movie based on a dramatic true story has been filmed for free-loan use by community groups and employee audiences.

"The Mark Waters Story" recreates the heartbreaking but heroic drama of a newspaperman who wrote his own obituary while dying of lung cancer. His by-lined story reached millions of readers throughout the world when it was reprinted by *Reader's Digest* and other publications.

It began with this memorable statement: "Cigarettes were the death of me."

Richard Boone, star of screen and television ("Palladin"), volunteered his services to direct the film and play the role of Mark Waters.

Requests for playdates of "The Mark Waters Story" may be sent to Modern Talking Picture Service, 2323 New Hyde Park Road, New Hyde Park, New York 11040.

The following is an address made by the Honorable G. Elliott Hagan before the Second Biennial GaMPAC Workshop in Atlanta on October 11, 1969. Mr. Hagan is a Member of Congress representing the First Congressional District of Georgia.

Special Article

R for Good Government— A Congressman's View

HON. G. ELLIOTT HAGAN, M.C., *Washington, D.C.*

LADIES AND GENTLEMEN, it's good to be back in Georgia. . . .

I had half expected the flags to be flying at half-mast, after that run-off for the National League pennant.

But life seems fairly normal . . . the sun still shines, the birds still sing, and the fans of the Atlanta Braves are still saying "just wait until next year!"

I was sort of toying with the idea of introducing a bill to outlaw the New York Mets. But a week of spiritual convalescence has caused me to abandon the idea . . . after all, I have spent most of my political life trying to keep government's nose *out* of other people's business, and I might as well be consistent about it.

I've been in enough political cliff-hangers to know whereof I speak, when I say that I might not be in Congress today if it weren't for the doctors and doctors' wives of Georgia.

And I have colleagues in Congress—on both sides of the aisle—who will tell you the same thing about the doctors in their states. Yet it wasn't too many years ago that people were saying that doctors were political zeros. They were castigated, criticized and maligned, as members of an affluent profession who were not shouldering their fair share of the responsibility for helping elect a government mindful of constitutional principles and based on the free enterprise system.

Unfair Charges

The fact is, those charges were unfair. . . .

There is no period in the history of man when

doctors of medicine have not participated in government or served as leaders in their country. Twenty-eight physicians served in the Continental Congress of 1774. Five physicians signed the Declaration of Independence. . . .

Over the years, physicians have served in the Cabinet and on the Supreme Court. One—William Henry Harrison—was a President of the United States. They not only participate, they take the lead. The first governors of Delaware, Kansas, Connecticut, Ohio, and Alabama were physicians.

Many other physicians have served as governors of their state, also. Three-hundred and sixty-nine doctors have served in the various Congresses since the first Continental Congress. They have served in every Congress since 1775.

Nevertheless, despite that proud record, those charges were made and only seldom defended. . . . Why?

Method Criticized

The answer, I think, was not so much that you were inactive, or disinterested. The criticism was really directed at the *way* you went about politics.

Ever since the founding of our country, prominent physicians across the nation have had a direct and forceful influence on politics. As times changed, the voices of those powerful and influential individuals got lost in the sea of voices seeking political recognition. They could no longer be identified.

Medicine was not alone in this problem. . . .

Some 30 years ago, a small group of highly intelligent, very determined men sat down to tackle a similar problem. Their legislative aspirations were

not being realized, and their lobbyists couldn't seem to do much about it.

These men were tough-minded realists . . . they had reached the top in their profession by being tough-minded—by seeing things as they *were*, not as they would *like* them to be. They were the leaders of labor, and until 1935, they and their unions had played only a relatively minor role in national politics.

Recognized Importance

These men recognized the importance of what they had going for them in that crucial year . . . the official and political blessing of the Roosevelt Administration and the newly-passed Wagner Act. Quick to sense the political implications of these developments were such CIO leaders as Walter Reuther and Sidney Hillman—men whose outlook was political and whose political I.Q. was lofty.

Leaders like Reuther and Hillman found, ready at hand, the two basic requirements for political strength: money and manpower.

To the problem of how to get Congress to do what Labor wanted done, the solution was simple . . . elect a Congress responsive to Labor's wishes, a Congress composed of men and women who owed their election in whole, or in substantial part to Labor's support during the campaign.

Year after year the CIO's political action committee gained strength, until FDR's remark "Clear it with Sidney" expressed no more than a political fact of life. For Sidney Hillman was indeed a power in the Democratic Party's counsels, and so were his colleagues of the CIO.

Powerful Minority

With the merger of the AFL and CIO came the most powerful minority political organization in the nation's history—COPE. And if you doubt it, consider the record as of the end of 1960. That year, at least half of the members of the Senate were substantially COPE supporters. About 200 to 225 members of the House—a slight majority—also voted right as COPE saw it, at least in a majority of cases.

In 1958, the year in which the Democratic victory changed the entire balance of power in the Senate, COPE publicly announced that it had backed 17 of the 23 successful candidates for governor.

In the 1960 presidential campaign, COPE's contribution to the election of President Kennedy was incalculable. Let's not say that it provided the margin between victory and defeat, for the margin was

so narrow that any one of a half a dozen factors could have spelled the difference.

Let's say instead that COPE's contribution of money and manpower made the difference between skin-of-your-teeth victory and solid defeat. Please understand me . . . I am not against Labor, although I am sometimes against some Labor leaders.

I am not against the Democratic Party; as you know, I am a Georgia Democrat, and proud of it. But I am opposed to the dominant wing of the National Democratic Party, which in recent years has departed so radically from the principles Thomas Jefferson espoused.

Group Action

COPE has put into practice a political reality: group action. It has done as a group what its individual members could not do separately. Unfortunately, doctors did not learn that lesson until some years later, when medicine organized its political action movement. But when you learned it, you learned it well . . . that's not surprising.

Politics is a very pragmatic activity. It requires realism on the part of those who practice it. So it was predictable that physicians, trained as they are in the scientific method, would display the sort of realism it takes to get political results.

The PAC movement itself is based upon the realistic premise that individuals are easily lost in the political process, but can be effective—enormously effective—if they join forces in a common endeavor.

And so you have developed the capacity for group political action, and the only criticisms I hear in political circles are no longer based on physician inactivity . . . they are based on the fact that you are *too* darned active for some people's liking!

Oddly enough, though, some of your colleagues in medicine still don't get the message . . . some of them seem to think that political involvement is somehow demeaning to a physician, and that medicine and politics don't mix.

Politics and Power

The fact is, that politics is the matrix from which government evolves; and that government has a say in the way life is lived by every individual, every profession, every corporation in this country.

I'm reminded of the man who bought a three-month-old gorilla:

"How much does this gorilla weigh?" he asked the trainer.

"About 275 pounds," the trainer said.

"How tall is he?" the man asked.

"About five feet," the trainer said.

"How big will he get?" the man asked.

"Full-grown, about six feet nine and six hundred pounds or so," the trainer replied.

"Gosh," the man said. "Tell me, where does a big animal like that sleep?"

"Well, mister," the trainer said, "when you get a gorilla that big, he sleeps where he darned well pleases."

Restrain Government

My friends, government is like that . . . if it gets big enough, and powerful enough, it will do anything it darned well pleases. Unless you restrain it, it can raise your taxes to ruinous levels; mortgage the future of generations yet unborn; nationalize the railroads; regiment the medical profession; or make spitting on the sidewalk a capital offense.

In short, government can do anything that you—the citizens who create it—allow government to do.

So it boils down to this: either *you* run the government, or *most assuredly* the government will run *you*.

And how is government created? Through that harrowing process called politics. You simply vote candidates into office and hope for the best. The electorate is then stuck with its selections until the next election, whether the office-holders do a good job of helping to govern or not.

Choose Wisely

If the electorate is to choose wisely, it had better find out where the candidates stand on the issues *prior* to the election, and then work to help elect those who pretty much reflect its own views.

That course is a great deal more productive than bemoaning the shortcomings of a Congress, a President, or the man in the Governor's mansion, *after* you have elected them.

Edward Everett Hale, while Chaplain of the United States Senate, was asked: "Do you pray for the Senators, Dr. Hale?" "No," he replied, "I look at the Senators and pray for the country."

Anyone who knows me well can tell you that I am second to none in my belief in the power of prayer.

But it seems to me that people fortunate enough to live in a Republic are obliged to do more than pray for their country, for this places an unfair share of the burden on the heavily-laden shoulders of God Almighty!

Need for Involvement

This, then, is what I wish I could tell every doctor and doctor's wife who is not active in GaMPAC. The very fact that you are present here today, testifies that you accept the need for political involvement, and that you understand the strength that a group of intelligent people can exert when they work together.

There is an Indian tribe in Brazil that requires anyone who talks politics to stand on one leg throughout his talk. It is a custom that has much to recommend it, but I am grateful that we don't have it here in Georgia. Otherwise, I'd have a pretty exhausted leg at this point.

So allow me to close by saying how grateful I am to the men and women of the medical profession for past support, and how reassuring it is to know that you are political activists.

May your numbers increase, not only in Georgia but in every other state of this great nation.

I speak for every Member of Congress who shares our beliefs, when I say that your backing, and the backing of other groups like yours, are the country's best hope for good government.

MAKE YOUR VOICE HEARD IN POLITICS AND GOVERNMENT . . . Thank you.

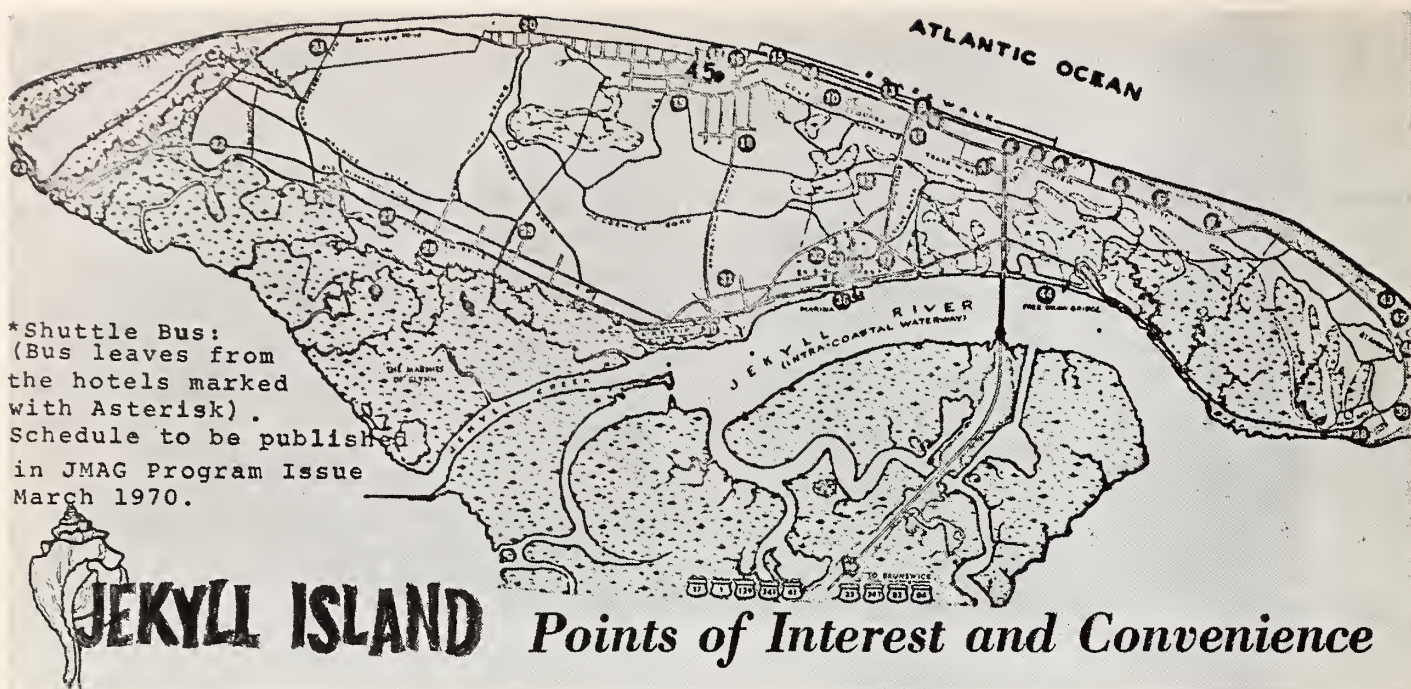
Cannon House Office Building

SCHOLARSHIPS OFFERED

Applications are now being accepted for the E. V. Allen Memorial Scholarships, open to junior and senior medical students attending medical schools in the United States or Canada. The scholarship provides three months of cardiovascular study at the Mayo Clinic, Rochester, as well as \$1,000 award.

Deadline for applications is April 1, 1970. Applicants will be notified by May 1, 1970.

Brochures may be obtained by writing to Minnesota Heart Association, 4701 West 77th Street, Edina, Minnesota 55435.



1. Shopping center, Authority office, post office, police.
- *2. Aquarama containing 2,500 seat convention hall with indoor heated pool.
3. South public bath house.
- *4. Corsair Motel and Restaurant.
- *5. Buccaneer Motel and Restaurant.
- *6. Carriage Inn Motel and Restaurant.
7. South picnic area.
8. Parking area.
9. Beach concession stand.
10. Ocean-side golf course.
11. Golf clubhouse and miniature golf course.
12. Eighteen-hole championship golf course.
13. Beach walk—1¾ miles fronting ocean.
14. North public bath house.
15. Beach concession stand.
- *16. Wanderer Motel and Restaurant.
- *17. Jekyll Estates Motel.
18. Oakgrove residential area.
19. Palmetto residential area.
20. Jekyll Beach residential area.
21. North picnic area.
22. Cherokee Campground.
23. Driftwood Beach.
24. Clam Creek fishing and picnic area.
25. Ruins of Major Horton's House.
26. Historical DuBignon Cemetery.
27. Ruins of Georgia's first brewery.
28. Picnic Area.
29. Plantation residential area.
30. Paved airstrip.
31. Pinegrove residential area.
32. Auditorium.
33. Faith Chapel.
34. All-weather tennis courts and clubhouse.
35. Jekyll Club Hotel and Village Area.
36. Jekyll Island Marina and boat docks.
37. Jekyll Island Museum.
38. Picnic Area.
39. St. Andrews residential area.
40. Miniature golf course.
41. Proposed Teen Center.
42. Beach casino and recreational area.
43. St. Andrews Auditorium.
44. Proposed yacht basin.
- *45. Seafarer.

THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 7, 1970

- 11:00 a.m.—Registration Opens, Aquarama
 11:30 a.m.—Auxiliary Pre-Convention Board Luncheon, Buccaneer
 1:30 p.m.—First General Meeting, Aquarama
 2:30 p.m.—Specialty Society Meetings (See March Program Issue)
 6:00 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 8, 1970

- 9:00 a.m.—Second General Meeting
 First Session of House of Delegates and Calhoun Lectureship, Aquarama
 9:30 a.m.—Auxiliary General Meeting, Buccaneer
 2:00 p.m.—General Meeting, Aquarama
 6:00 p.m.—Alumni Receptions and Dinners (See March Program Issue)

Saturday, May 9, 1970

- 9:00 a.m.—Reference Committee Meetings, Carriage Inn
 Auxiliary General Meeting, Buccaneer
 12:00 noon—Auxiliary Luncheon, Buccaneer
 2:00 p.m.—General Meeting, Aquarama
 6:30 p.m.—MAG Annual Reception and Banquet, Aquarama

Sunday, May 10, 1970

- 9:00 a.m.—Auxiliary Post Convention Board Breakfast, Buccaneer
 9:00 a.m.—Third General Meeting and Second Session of House of Delegates, Aquarama
 12:00 noon—Adjournment

Medical Association of Georgia Annual Session

May 7-10, 1970—Jekyll Island, Georgia

RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
(Motel of your choice)
Jekyll Island, Ga. 31520
2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible confirmation will be in accordance with preference indicated, if not, best substitute will be made.
4. Unreserved accommodations will be released on April 23, 1970.
5. A deposit in the amount of one night's lodging, plus 3% Georgia State sales tax, is required to assure your reservation. Make check payable to motel of your choice.
6. Rooms will not be ready for occupancy until 3:00 p.m. on day of arrival. Check-out time is 12:00 noon on your departure date.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Name of Motel		Bedroom 1-2 persons	Kitchenette 1-2 persons	Each Additional Person
Buccaneer Motor Lodge	(Ocean)	\$17-20	\$20-24	\$1.00
	(Court)	\$16-18	\$18.00	\$1.00
Corsair Motel	(Ocean)	\$21.00	\$22.00	\$2.00
	(Drive)	\$18.00	\$19.00	\$2.00
Stuckey's Carriage Inn	(Pool)	\$21.00		\$2.00
	(Drive)	\$19.00		\$2.00
Wanderer Motel	(Ocean)	\$20.00	\$21-26	\$2.00
	(Drive)	\$17.00		\$2.00
Seafarer Motel	(Drive)	\$18.00		
Jekyll Estates Motel	(Ocean)	\$18.00		

ALL RATES PLUS 3% GEORGIA STATE SALES TAX

Cut out and send to motel of your choice:

Please type or print

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION
MAY 7-10, 1970

NAME

ADDRESS

CITY & STATE ZIP

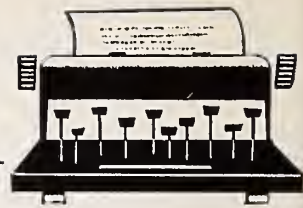
ARRIVAL DATE DEPARTURE DATE

I DESIRE ACCOMMODATIONS AT (1st) (2nd) MOTEL.....

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS

I DESIRE TRANSPORTATION FROM TO MOTEL.....

FLIGHT # TIME



Our New Headquarters—Here and Now

BY THE TIME this issue of the JOURNAL reaches you, the new MAG Headquarters Building will have been completed *in toto* and the key to our new home will have been presented to the President and the Council. (All we have to do now is pay for it over the next 19 years.)

It is a magnificent structure. Architects continue to amaze me when they can listen to your needs and requirements for a building, then sit down and reduce it all to drawings and sketches that a building contractor can follow and have it come out correctly, even to the amount of money you're likely to have to spend. Congratulations to our architects, Thompson and Hancock, and to our contractors, Marthame Sanders and Company, for a job well done.

It's so much better for the Georgia Regional Health Program and the Military Medicare program to be under one roof with our Headquarters office, rather than being scattered all over town. Communication between these programs is vital. It is a responsibility of the doctors of Georgia to see that these programs work well.

Every foot of space in the new annex is occupied by the Georgia Regional Medical Program. They are quite happy and exceedingly well-pleased with their new set-up. The rejuvenated old building is occupied by the Headquarters staff, the Military Medicare program and a very pleasant office for the Woman's Auxiliary. We have a small, unused area which is being reserved for future expansion of MAG.

Building Delays

By and large, everything went along with the building about as expected. I have never had anything to do with building, remodeling, painting or anything else that was completed at the given time—something always delays it. In this case, we had a painters' strike, just at the time we needed them most. This fouled everything for several months. Material ordered and promised at a specified time failed to arrive. Rains, cave-ins and all those things were frustrating, but the contractors, architects, workers and Mr. Ed Smith finally made it.

In case that you do not know or have forgotten, the 1968 House of Delegates instructed the Building Committee and the Council to build an additional 10,000 square feet onto the old building, to remodel the old building and to build a foundation that would support an additional 50,000-60,000 square feet above it, should the need arise, and also to build enough parking area at this time to accommodate any future expansion. This has been accomplished—the building, the foundation, one street level parking deck, and two sub-basement parking decks.

The total guaranteed cost of the building was not to exceed \$729,000. At present, it looks as though it is going to cost about \$700,000.

It seems to me that the doctors of Georgia are to be congratulated. Too often we have been criticized, and we have criticized ourselves for doing too little,

too late. I think the House of Delegates recognized the need of this building and the possible need of future expansion. They acted instead of dragging their feet, and ordered it built.

It is your building. Come by sometime. You can have a free parking space, see your new home, and Miss Franklin, the custodian of the shekels, might even give you a cup of coffee.

*J. G. McDaniel, M.D., Chairman,
Building Committee
John S. Atwater, M.D.
F. G. Eldridge, M.D.*

Criteria for Selection of Recipients of MAG Awards

GENERAL PRACTITIONER OF THE YEAR—This award is presented to an outstanding General Practitioner in Georgia. Selection of the recipient will be made by the House of Delegates from ballots cast during the first session of the House. The Georgia Academy of General Practice and component county medical societies are invited to make one or more nominations for this award. No nomination will be considered unless accompanied by supporting biographical data and received at the headquarters office of the Medical Association of Georgia at least two weeks prior to the opening of the Annual Session. No nominations for this award may be made from the floor of the House. The president of the Georgia Academy of General Practice will present this award at the final general session of the Annual Meeting.

HARDMAN AWARD—This award is presented for "the achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery," or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor of the House. If given, this award will be presented at the final general session of the Annual Meeting. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter from the late Governor Hardman establishing this award.

DISTINGUISHED SERVICE AWARD—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and

must be received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. If no nominations and supporting data are received, no award will be given. The recipient will be selected by a five-man secret committee and presentation will be made at the final general session of the Annual Meeting.

CIVIC ENDEAVOR AWARD—This is a new award available for presentation for the first time at the 1969 Annual Session and will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award, supported by appropriate data which must be received at the headquarters office of the Medical Association of Georgia at least two weeks in advance of the Annual Session. If no nominations and supporting data are received, no award will be given. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the final general session of the Annual Meeting.

CERTIFICATES OF APPRECIATION—The Committee on Awards will make recommendations to Council as to whom Certificates of Appreciation should be given. The Council of the Medical Association of Georgia retains the prerogative to add such names to this list as they deem wise. The Committee on Awards did not favor the automatic giving of Certificates of Appreciation to retiring committee chairmen unless, in the opinion of the committee or Council, such chairmen have performed good and deserving work. The committee points out consideration for these Certificates of Appreciation might well be extended to non-medical groups or corporations who have made outstanding contributions to medicine.



BROTHER, CAN YOU SPARE NINETY SECONDS?

ARTHUR GORDON, *Savannah*

THERE'S A QUESTION I think we doctors should ask ourselves—or at least have in the back of our minds—when we're able to give a patient back his health, or even his life. The question is: "What is he going to do with that health, do with that life?"

No concern of ours? I think it is. We're supposed to be concerned with the whole man, not just his broken leg or infected sinuses. What's more, we're in a position where we can exert a lot more influence than some of us think. People still listen to their doctor when they won't listen to anyone else. They believe what we say. They welcome our opinions, our advice, our ideas. We have a ready-made bridge over the communications gap. Why don't we use it more? A great opportunity is going to waste.

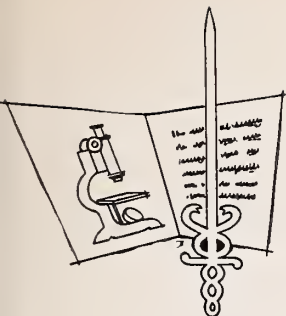
Not only could we help people more than we do, we'd be helping ourselves. Our image, as the Madison Avenue boys say, could be better. As medical costs increase, doctors tend to be blamed. People are complaining that every year medicine gets colder, more impersonal, less compassionate. There's just one way to counteract this: be interested in them, not just as patients, but as people. Ask them a couple of questions, now and then, *not* related to the immediate medical problem. About their jobs. Their wives. Their children. Even their politics, because—who knows?—something you might say might influence them to vote, or write their Congressmen—along helpful lines.

Time? It doesn't take that much time. Ninety seconds now and then would do. Give it a try!

(Mr. Gordon, a personal friend of President Train, is a noted author and feature story writer. Dr. Train persuaded him "to give the JOURNAL a sample of his talent. He was kind enough to produce the above, which should give us all something to think about.")

A handwritten signature in dark ink, reading "John Kirk Train". The signature is fluid and cursive, with a large initial "J" and "T".

John Kirk Train, M.D.
President, Medical Association of Georgia



DOES MAN REACT AGAINST CANCER IMMUNOLOGICALLY?

LOREN J. HUMPHREY, M.D., Ph.D., *Atlanta*

DURING THE PAST 20 YEARS, the search for methods of improving cancer cure rates has been intensified. Improvements in cure rates and control of incurable cancer have been effected by refinement of existing techniques and by patient education, rather than by more radical operations or x-ray therapy. Combination therapy such as surgery plus chemotherapy or cobalt plus surgical resection, while helpful, have been disappointing in offering only slight improvement. Just as disappointing has been the failure to find cancer specific chemotherapeutic agents. Hence it is easy to understand the eagerness of the public and the medical profession in general to pass the gambit on to some new but yet unproven modality as the anti-cancer treatment of the future. The very great interest and enthusiasm for immunotherapy over the last two years would seem to indicate that the treatment of choice in the future must be some type of immunotherapy. Have our frustrations over the inability of surgery, chemotherapy and x-ray to retrieve our therapeutic failures forced on us a modality that has little chance of succeeding? Certainly it would seem to be most logical to think in terms of stimulating the body's own defense mechanisms to handle the cancer problem. Let's examine in general the evidence supporting the contention that man does have immunity to his own cancer.

Proof of the existence of tumor specific immunity in animal tumor systems in 1953 by the use of in-bred strains of animals opened the door for tumor immunology. Such studies brought forth evidence showing tumor specific antigens and stimulated work on oncogenic viruses and the malignant transformation of normal cells in animal systems. With this type of evidence it became less difficult to think that similar types of antigens and agents might be operative in human cancers.

Interestingly, in the middle 50's physicians became suspicious that stress might lower host resistance so that the patient's cancer would grow in an accelerated rate and lead to an earlier demise. This was documented by several cases in which following unsuccessful surgical exploration, metastatic tumors were noted to appear at an accelerated rate thereafter. Many investigations were carried out to explore the effect of stress on tumor takes in animals and surprisingly few people at this time, even though using this stress tumor-take model, would admit that there was a normal host resistance in controlling the patient's cancer.

Spontaneous Regressions

About the same time spontaneous regressions were reported in greater and greater numbers and finally Cole and Everson collected the world experience and

showed that indeed there were not just one or two cases but several in the world literature of proven spontaneous regressions. This further raised the question that perhaps some sudden increase in the host's own resistance resulted in the disappearance of the tumor. At about this time Sumner and Foraker reported that they had taken the serum from a melanoma patient who had undergone a spontaneous remission and infused the plasma into a second patient with melanoma. They noticed some objective response. This report stimulated the medical profession to feel more strongly that man did have an immunologic defense against cancer.

Naturally, many investigators therefore assumed that the patient who is cured or whose cancer is well controlled has great immunity and therefore the patient who has disseminated cancer could be demonstrated to have very poor immunity. Hence it was not surprising when many investigations since that time have shown that the terminal cancer patient is immunologically unresponsive. The argument can always be raised that this is merely just a manifestation of poor protein synthesis due to the emaciation accompanying the terminal state of the patient and not due to any specific lack of immunologic responsiveness. This argument is raised repeatedly because of our inability to show that the patient early in the stage of disseminated cancer compared to the patient with localized cancer has a deficient immunologic responsiveness. On the other hand, we must recognize that present methods for evaluating immunologic responsiveness in man are extremely crude so that we would still accept anergy in the terminal cancer patient as suspicious evidence indicating that the patient with widely disseminated cancer has some defect in his immune mechanism.

Recently several investigations have brought forth evidence of a more direct nature which shows that by stimulating man's reticuloendothelial system, cancer can be controlled more favorably. For example, Mathe has autoimmunized patients with leukemic cells in BCG and noted a prolonged remission period for their leukemia. Quite interestingly, at the same time a control series of patients received BCG only (an adjuvant which boosts the immunity non-specifically) and noted the same prolongation of remission in leukemic patients. Southam has reported that after amputations of osteogenic sarcoma, a portion of the patient's tumor is exposed to x-ray to attenuate the viability of the tumor. He gives his vaccine back to the patient and has observed a prolongation of the disease-free interval before dissemination is noted. Mechanisms of response to this type of autovaccination have not been elaborated but, taken at face value, we must admit that this is evidence that the immunologic responsiveness of man can be altered to help control his cancer even if for a short time interval.

Control Through Immunotherapy

Immunotherapy programs which have used the exchange of tumors followed by exchange of white blood cells alone or plasma and white blood cells together have brought forth further evidence to make control of cancer by immunotherapy tenable. All of the programs using cross-exchange of different types of tumor preparation have noted an occasional case in which the patient's cancer has disappeared completely and many other patients in whom there is some objective response for from two weeks to two years. A wide spectrum of the type of response is seen; a temporary decrease in tumor size, cessation of growth temporarily or for prolonged intervals, and in some instances, complete regression of tumor nodules.

Unfortunately at this point in time, there is no evidence to indicate whether the clinical responses observed by those using immunotherapy are due to the immunization with a tumor preparation, the exchange of plasma and white blood cells, or a combination of this active and passive form of immunity. Certainly the responses are seen frequently enough to convince us that man can react to cancer.

Perhaps one of the more exciting but preliminary pieces of evidence has come forth following the immunization of patients with tumor tissues of a histologic type unrelated to their own histologic type. This type of cross-reactivity or "anti-cancer" activity stimulates hope that man's immune system can react to "cancer" and not just to a specific organ type as thyroid cancer, ovarian cancer, colon cancer, etc. The few laboratory tests that seem to evaluate serologically man's response to tumor immunization support this contention; i.e. antitumor activity in the serum of patients vaccinated with different tumors cross reacts with tumors of several different histologic types.

Data brought forth in recent years leaves little doubt that man can be stimulated to react against cancer and that those patients with the least amount of disseminated disease do so much better than those patients that have large metastatic lesions or those that are terminal. The mystery of man's reaction to cancer can best be solved by backing up clinical cancer studies with strong laboratory testing programs.

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H. M. Pollard, M.D., Ann Arbor, Mich.

Gastroenterology

Walter Lane, M.D., Tampa, Fla.

General Practice

Henry Clay Frick, II, M.D., New York, N.Y.

Gynecology

William H. Crosby, Jr., M.D., Boston, Mass.

Internal Medicine

Thomas L. Petty, M.D., Denver, Colo.

Internal Medicine

David N. Danforth, M.D., Chicago, Ill.

Obstetrics

Jack A. Dillahun, M.D., Albuquerque, N.M.

Ophthalmology

John J. Niebauer, M.D., San Francisco, Calif.

Orthopedic Surgery

William K. Wright, M.D., Houston, Tex.

Otolaryngology

Omer E. Hagebusch, M.D., St. Louis, Mo.

Pathology

Chester M. Edelman, Jr., M.D., Bronx, N.Y.

Pediatrics

Howard P. Rome, M.D., Rochester, Minn.

Psychiatry

Wendell P. Stampfli, M.D., Denver, Colo.

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HEART MURMURS IN PREGNANCY

ALLAN BLEICH, M.D., *Atlanta*

NUMEROUS STUDIES HAVE BEEN REPORTED concerning the management and prognosis of heart disease in pregnancy, but little attention has been given to the auscultatory changes associated with pregnancy. It has been generally appreciated that heart murmurs may develop during pregnancy and give a false impression of organic heart disease. Conversely, it has recently been noted that certain murmurs of organic heart disease may diminish in intensity or become inaudible during pregnancy.

Patients Without Evidence of Organic Heart Disease

SYSTOLIC MURMURS: In over 90 per cent of patients a systolic murmur is heard during pregnancy. This murmur is usually ejection in character, less than grade three in intensity, is often accompanied by a prominent third heart sound, and has been attributed to increased blood flow across the pulmonic and aortic valves. Another systolic murmur frequently evident during pregnancy is the innocent supraclavicular arterial murmur. This is heard maximally in the supraclavicular fossa and over the carotid vessels but may be transmitted to the upper precordium. The majority of systolic murmurs present during gestation disappear or decrease in intensity shortly after delivery.

DIASTOLIC MURMURS: The presence of a diastolic murmur during pregnancy should suggest organic heart disease. However, two types of functional diastolic murmurs have been described as being heard occasionally during pregnancy and disappearing postpartum. I have not been able to corroborate this. One is a low frequency murmur heard best at the left sternal border in mid diastole. This is attributed to increased flow across the tricuspid valve. The second is an early diastolic murmur maximum over the pulmonic area. This is considered to be due to functional dilatation of the pulmonary artery during gestation.

CONTINUOUS MURMURS: The cervical venous hum, a continuous bruit in the neck, is usually audible during pregnancy as it is in other high output states. It is produced by increased velocity of blood flow in the jugular veins and may radiate to the upper precordium, causing an incorrect impression of organic heart disease.

Extra cardiac murmurs may develop during pregnancy. These murmurs may be either systolic or continuous and are most commonly heard over the right or left second intercostal space, one or two centimeters from the sternal edge. These murmurs originate in the mammary artery or veins. Pressure over the appropriate vessel obliterates the murmur.

Patients With Valvular Heart Disease

Recently it has been shown that the murmurs of aortic and mitral regurgitation may diminish in intensity or even become inaudible during pregnancy. These

changes are apparently due to the diminished vascular resistance characteristic of pregnancy. When the peripheral vascular resistance was increased by giving phenylephrine intravenously, the murmurs of mitral and aortic regurgitation increased in intensity, usually to the level present in the nonpregnant state. The murmur due to mitral stenosis may increase in intensity during pregnancy. The effect of pregnancy on heart murmurs due to other valvular and congenital abnormalities has not been adequately documented.

An understanding of the effects of pregnancy on heart murmurs is important to avoid making the erroneous diagnosis of organic heart disease in a normal patient. It is also important to determine the existence of valvular heart disease, since endocarditis is a hazard during parturition.

Suite 229 B

490 Peachtree Street, N.E.

THE ANNUAL SESSION—1970

Annual meetings are many things. They are scientific forums, social events, periods of relaxation, business sessions, class reunions, and many, many more. Every physician in Georgia can find many good reasons to attend the MAG Annual Session.

This year the Medical Association of Georgia returns to a scene of many pleasant memories—Jekyll Island. The Annual Session will begin on Thursday, May 7, and continue until Sunday, May 10. Such an arrangement makes it possible to enjoy a sparkling week-end at the beach, and as all Georgians know, May is a good time of the year to be at the beach. Now let's take a brief look at what will be on tap for physicians, their wives and guests:

Scientific Sessions

Friday and Saturday will feature MAG's excellent scientific programs—the result of a lot of hard work by the Program Chairman. The MAG Scientific Sessions, which are presented in addition to the individual scientific programs of the specialty organizations, are of general appeal, and consist of one brief, but outstanding panel each afternoon. Friday's program entitled, "Government and Medicine" features Wilbur Cohen, former Secretary of Health, Education and Welfare; Dr. James Harkess, Kentucky physician who formerly practiced under the British National Health Service; and Mr. James Jackson Kilpatrick, nationally syndicated columnist from Washington, D.C. Saturday's outstanding scientific session is entitled, "Man, Moon and Medicine" and features Dr. Charles Berry, Medical Director of the NASA Manned Spacecraft Center, Houston, along with one of our nation's astronauts. Also featured on this panel will be the Rev. Dr. Paul McCleave, Director of the AMA's Medicine and Religion Program.

Specialty Societies

In addition to the MAG scientific sessions, Thursday has been set aside as Specialty Society Day, giving each of the specialties an opportunity to have their own business and scientific sessions.

Exhibits

The Aquarama will be the scene of the technical

and scientific exhibits, as well as the scientific sessions. No matter how hard we try, we cannot sufficiently stress the importance of all physicians visiting the exhibits.

Auxiliary

The Woman's Auxiliary to the Medical Association of Georgia has planned a complete schedule of activities for all doctors' wives attending the Annual Session.

House of Delegates

The governing body of the Association will meet on Friday and Sunday, and all members of MAG are welcome—in fact urged—to observe their delegates at work. A special area will be reserved for observers.

Perhaps the most important work of all is conducted during the meeting of the Reference Committees on Saturday. It is in these meetings that members have an opportunity to speak for or against any resolutions or reports introduced during the first session of the House. It is here that we learn first hand just exactly how you feel about key issues before the governing body of MAG. Your thoughts and suggestions will be given every consideration when the Committees write their reports and make known their recommendations to the House on Sunday.

Social Events

Each evening during the annual meeting will feature different and exciting social events. Thursday evening is reserved for specialty society parties and dinners; Friday evening is reserved for alumni association parties and dinners; and Saturday evening is the time for the annual MAG Banquet. The host, Glynn County Medical Society, will present a party for the MAG preceding the annual banquet on Saturday evening.

The 1970 Annual Banquet will be in the form of a Hawaiian Luau with sports attire, such as bright shirts and dresses replacing the usual formal attire. Professional entertainment will be provided by a native Polynesian troupe called the "Pearls of the Pacific."



STAFF PRIVILEGES IN PRIVATE HOSPITALS

JOHN L. MOORE, Jr., *Atlanta**

THE OHIO VALLEY GENERAL HOSPITAL ASSOCIATION, a private nonprofit corporation, operated the Ohio Valley General Hospital and the Wheeling Hospital both in Wheeling, Ohio County, West Virginia. Both hospitals had, as a part of their staff rules, the following:

“Except under extraordinary circumstances, physicians having their offices and practice outside of Ohio County shall not be eligible for staff appointment or hospital privileges.”

The two hospitals served an area population of over 250,000 people encompassing six counties besides Ohio County. Residents of Ohio County, West Virginia, constitute between 44 per cent and 49 per cent of the patient population in both hospitals.

Ohio Valley General Hospital received in excess of \$3,000,000 of Federal Hill-Burton funds to assist the construction of a new addition at a total cost of nearly \$10,000,000. A new wing at the Wheeling Hospital costing \$1,264,000 was paid for in part with the use of \$625,000 of Hill-Burton funds. In both instances, private contributions from Ohio County accounted for an appreciable part of the remainder of the cost.

A pediatrician, a surgeon, and an obstetrician and gynecologist sued the Ohio Valley General Hospital Association. The plaintiffs all practiced immediately across the river from Ohio County, West Virginia, in Bellaire, Belmont County, Ohio. They served patients in Ohio County as well as in Belmont County, Ohio. The court, in summarizing the facts, stated:

“With three clinics, their patient lists cover almost the identical geographical range of the defendant hospitals.”

The plaintiffs were not equipped with facilities for specialization matching those of the two hospitals operated by the defendant. All parties admitted that the exclusionary rule was hurtful to the plaintiffs’ medical practice.

Holding by the Court

The United States Court of Appeals for the Fourth Circuit found in favor of the plaintiffs and held that they had a right to be admitted to full staff privileges in the two hospitals owned by the Ohio Valley General Hospital Association.

The Court specifically held that the benefits flowing from Federal funds under the Hill-Burton Act entailed, in return, obligations of observance of Federal con-

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

stitutional mandates. The Court found, therefore, that disregard of such mandates constituted State action because the Hill-Burton Act entrusts the State to maintain a fair and just governance of hospitals accepting the aid of the legislation. The Court pointed, for example, to the necessity for the filing of a State plan. The Court carefully pointed out that no racial considerations were involved in this case but held that the constitutional principles developed in Civil Rights cases applied in full strength to this non-racial case.

The Court then examined whether the discrimination involved was reasonable in fact. If there were any reasonable basis for the discrimination, then the Court would not disturb the exclusionary rule. However, the Court found that the particular rule was frivolous and unnecessary. The Court pointed to the fact that the plaintiff physicians' patients came from the same geographical area generally served by the hospitals. It pointed out that while contributions were provided mainly by residents of Ohio County, those residents had recognized that it was to their interest to provide larger facilities with better resources and, therefore, actively sought patients from the seven-county area. The Court then found that the exclusionary rule only favored physicians who actually had offices in Ohio County and the rule did not support any policy of favoring the residents of Ohio County who had made the contributions originally.

Dissent

Chief Judge Haynsworth dissented. He stated specifically that he found no difference between him and the majority as to the governing legal principles. However, Judge Haynsworth emphasized the right of residents of a particular county to raise funds from their own residents and to limit the benefits of the hospitals to their own residents.

Comment

The holding in the reported case certainly has rather broad implications. First and foremost, the clear implication is that if a private nonprofit hospital receives Hill-Burton funds, it probably cannot initially exclude from staff membership any physician who practices in the same area especially if that area lies within the same county. Thus, if the implications of the reported case are carried to their logical extent, all hospitals receiving Federal grants under the Hill-Burton Act in the same medical service area may well have to admit all qualified physicians in the same service area to staff membership. Obviously, such hospitals have the power to impose reasonable restrictions upon the amount of practice in the particular hospital by particular physicians based on reasonable regulations as to their ability and experience.

There are also obvious implications of the reported decision bearing on cross-county metropolitan areas and on multi-state metropolitan areas.

Finally, it is interesting to speculate on whether the Federal courts may apply the same reasoning to nonprofit hospitals who have not used Federal monies from the Hill-Burton Act if such hospitals receive Federal income tax exemption because of their nonprofit nature. The Fourth Circuit did point out that the existence of a State plan under the Hill-Burton Act and the requirements on the State to regulate and license hospitals receiving Hill-Burton funds made a difference. However, it is logically but a small step to say that the reasonable price for tax exemption is the acceptance of Federal constitutional principles.

Suite 1220
C & S Bank Building

* The case discussed is *Sams v. Ohio Valley General Hospital Association*, 413 F.2d 826 (4th Cir. 1969).

THE ASSOCIATION



SOCIETIES

The Muscogee County Medical Society has elected new officers for the coming year. Abe Conger was installed as president, Harry H. Brill as president-elect, and Jack Lawler, secretary-treasurer.

PERSONALS

First District

Lamont E. Danzig has been named medical chief of staff of Memorial Medical Center for 1971.

James C. Metts, Jr., chairman of Savannah's Community Cardiovascular Council, testified at Senate subcommittee hearings December 3 in an effort to save three stroke programs in the Savannah area.

Second District

John Anthony Ferrence has moved his practice to Mountainhome, Ga., from Whigham.

Paul W. Lucas spoke on increasing hospital costs at the November meeting of the Tifton Lions Club.

William McCollum, as a write-in candidate, won a post on the Thomasville City Commission.

Third District

Augustus S. Batts has been re-elected to active membership in the American Academy of General Practice.

Fourth District

Robert L. Bennett, Jr. discussed physical medicine techniques in the management of arthritis during a November forum on arthritis at the Fitzgerald Country Club.

Fifth District

Fred L. Allman will talk on the prevention and treatment of athletic injuries at the Alabama Education Association Convention in Birmingham, March 12.

Dale Dominy spoke on lung cancer and other diseases of the lung at the December installation of New Members of the Lilburn Lions Club.

Lewis E. Jones was named chief of staff of the Atlanta Veterans Administration Hospital in October.

Thomas R. Nolan participated in an International Symposium on the Local and Regional Treatment of Tumors in Turin, Italy, in October.

C. H. Wilson, Jr., discussed diagnosis and drug treatment of arthritis during a forum on arthritis November 22 at the Fitzgerald Country Club.

Seventh District

W. Dallas Hall has been selected recipient of the Research and Teaching Scholar Award of the American College of Physicians.

Harry Johnston moved his practice from Gilmer County to Chatsworth in Murray County in November.

Lewis R. Lang was elected chief of the Gordon County Hospital Medical staff at the November meeting of the group. J. A. Bishop was elected assistant chief and William R. Thompson, secretary.

Virginia Hamilton Shaw was named Woman of the Year by the Cartersville chapter of the Business and Professional Women's Club.

Ninth District

H. M. Edge retired from practice on December 1, after 27 years of service in Blairsville.

H. J. Ford began practice in Gainesville in November.

Tenth District

Preston Ellington spoke on the use and abuse of drugs at the November meeting of the Cartersville Rotary Club.

DEATHS

W. Wycliffe Hillis, Jr.

W. Wycliffe Hillis, Jr. died October 30 of a heart attack. Dr. Hillis was 43 years old.

He was a graduate of the University of Georgia and the Medical College of Georgia. He was a member of the Ogeechee River Medical Society, Medical Association of Georgia, Millen Rotary Club, the Alexander Masonic Lodge, and a member and deacon of the Millen Baptist Church. He was a veteran of World War II.

Dr. Wycliffe is survived by his widow, a daughter and two sons; mother, and a sister.

HIGHLIGHTS OF THE AMA HOUSE OF DELEGATES MEETING

The AMA House of Delegates meeting in Denver, Colorado, held in conjunction with the 23rd Clinical Convention of the AMA, took many important actions on a wide variety of subjects. This report is a summary only of the more important items from the meeting.

The House of Delegates of the American Medical Association began its deliberations in the Grand Ballroom of the Denver Hilton Hotel at 2:00 p.m. on Sun-

day, November 30, 1969, and in the course of its three days of activity, received and acted upon 95 reports and resolutions emanating from the AMA Board of Trustees, Officers, Councils and Committees, and Constituent State Associations. This meeting was a particularly gratifying spectacle for the Georgia Delegation since it marked the first appearance at the podium of the AMA's new Vice Speaker of the House, J. Frank Walker, M.D., of Atlanta. Dr. Walker per-

formed his duties in presiding over the AMA's governing body in his usually efficient style and was complimented by members of the House for the effective manner in which the business of the House was dispatched under his direction.

Private Practice

Several reports and resolutions introduced at this session called on AMA to establish a Council on Private Practice. As with some other issues before the House at this session, the matter of costs involved with the establishment of a new activity weighed heavily on the discussions and disposition. The House voted, in lieu of a Council of the House, to establish a standing Committee on Private Practice of the Council on Medical Service. The functions of the Committee on Private Practice shall be: (1) To encourage and promote the private practice of medicine; (2) To develop new methods that will promote the private practice of medicine throughout medical school, graduate and postgraduate training; (3) To assist the private practitioner to improve his method of providing medical care continually including business practices and the efficient utilization of allied health personnel; (4) To publicize to patients the merits of private practice; (5) To encourage and assist the development of similar committees by state medical associations; and (6) To maintain constant liaison with other committees and councils of the AMA to achieve these objectives.

Regional Medical Programs

Several reports and resolutions introduced to the

House dealt with the Regional Medical Programs and all contained the general tone of enthusiastic support for the operational projects funded under Public Law 89-239, which created RMP. The House of Delegates adopted a resolution in which it affirmed its support of the concept of Regional Medical Programs and urged the AMA membership to participate at all levels in implementing Regional Medical Programs "in line with the highest tradition of the private practice of medicine."

Medicare-Medicaid

The House took several actions regarding Medicare and Medicaid which can be summarized as follows: (1) Opposed on-site auditing in physicians' offices by representatives of governmental agencies; (2) Reaffirmed its position that AMA will assist Federal agencies in their quest for physicians who are errant in providing medical services to Medicare and Medicaid patients; (3) Opposed the indiscriminate release of names of physicians who have received payments under Medicare and Medicaid; (4) Directed the Board of Trustees to seek clarification of Medicare regulations regarding payments to physicians in teaching hospitals; (5) Moved to establish, through liaison with governmental third parties, corrected practices whereby carelessly framed or inappropriate wording in communications to patients results in needless misunderstandings regarding actions by physicians; and (6) Called on the Department of Health, Education and Welfare to spell out basic requirements of Medicaid, setting forth the minimum benefits specified by Title XIX of the Social Security Act, so that the states

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HIGHLIGHTS / Continued

might seek bids for pilot programs utilizing existing mechanisms for financing and delivery of medical services within the private sector, thereby providing a comparison with the existing Medicaid programs in an effort to determine the methods most beneficial to the patient.

RVS and CPT

The House of Delegates took note of the fact that the Second Edition of Current Procedural Terminology will be published early in 1970, and that it will contain the same five-digit procedure codes and nomenclature as used in the 1969 Revision of the California Relative Value Study, and added an expression of urgency to the publication. The House also indicated a desire that the National Association of Blue Shield Boards be encouraged to endorse the new codes and nomenclature, through appropriate committees of the Association.

Specialty Societies

The House of Delegates expressed its desire that the American Medical Association aggressively pursue close working relationships with the medical specialty societies. It adopted amendments to the Constitution and Bylaws implementing recommendations of the Report of the Ad Hoc Committee on the Modus Operandi of the Scientific Sections (Quinn Report) giving the specialties a greater role in the activities of the scientific sections, but requested all segments of the medical profession to work through the AMA structure in its relations with the Federal Government. It directed the Board of Trustees to consider calling a

conference of specialty groups within the medical profession.

Medical Education

The House of Delegates adopted a number of actions relating to Medical Education as follows: (1) Reaffirmed opposition to the establishment of a School of Health Sciences under the auspices of the Department of Defense; (2) Recommended that state and county medical societies take action to allow interns and residents to become active members; (3) Noted that progress was being made toward the establishment of a Commission on Foreign Medical Graduates and a Specialty Board on Allergy; (4) Called for the inclusion of socio-economics in the education of the young physician; (5) Established essentials of accredited educational programs in Orthopedic Assistants, Radiologic Technologists and approved residencies pertaining to Internal Medicine; (6) Expressed the desire that trainees be exposed to the merits of practice in a variety of environmental circumstances both in and out of hospitals; (7) Called on the Specialty Boards to accelerate action which will permit qualified Osteopaths to seek specialty board certification; and (8) In an effort to alleviate the physician shortage in the U.S. through expanding U.D. Medical School output by adequate funding, the House of Delegates stated that the AMA should influence the production of legislation which will provide educational monies for new medical schools and to assist those now in existence. The House in fact called for additional financial support from both the public and private sectors for Medical Education, and expressed its favor that financial support of research activity be encouraged from institutional rather than project grants.

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Hospital Staffs

The House of Delegates affirmed the provisions of the Joint Commission on Accreditation of Hospitals that the Governing Body of a hospital should delegate to the Medical Staff the authority to evaluate the professional competence of staff members and applicants for staff privileges, and should see that medical staff bylaws are developed and adopted, as policy of the Joint Commission.

Health Care of the Poor

The House of Delegates adopted a sweeping action regarding health care of the poor which will constitute new AMA policy in some instances. The new policy recommendations call for increased financial support for health programs of the poor; provision of methods to attract and retrain physicians and allied health professionals in areas of need; development of educational materials relevant to the cultural backgrounds of the poor and minority groups; assurance of adequate nutrition; elimination of exploitation through quackery; and increased participation of minority group physicians in AMA activities. The House, in a subsequent action, however, tabled a recommendation that AMA decide on new policy of requesting financial support from Federal agencies for the purpose of participation in Health Services research and development projects.

Marijuana

The House of Delegates adopted an official AMA policy statement on marijuana which stated (1) that marijuana is a dangerous drug and as such is a public health concern; (2) the sale and possession of marijuana should not be legalized; (3) the handling of offenders should be individualized and should include full evaluation of the need for treatment and rehabilitation, which should be provided as indicated; (4) additional research on marijuana should be encouraged; and (5) that AMA should continue its educational programs to all segments of the population with respect to the use of marijuana.

Institute for Biomedical Research

The House of Delegates gave thorough consideration to the intent and activities of the Institute. The research work of the Institute received the highest praise, but the House noted the impracticality of the Association continuing to meet the increasing financial burden for support of the Institute, and adopted a

report of the AMA-ERF Liaison Committee including its recommendation which called for the discontinuance of the Institute.

Smoking and Health

The House once again adopted a strong reaffirmation of its previous policy that (1) AMA urge its members to play a major roll against cigarette smoking by personal example and by advice regarding health hazards of smoking; (2) AMA discourage smoking by means of public pronouncements and educational programs; (3) AMA take a strong stand against smoking by every means at its command; and (4) AMA indicate to Congress its opposition to the expenditure of tax dollars to promote the production and sale of tobacco while at the same time spending other tax dollars to discourage cigarette smoking because of its hazard to health.

Therapeutic Abortion

Efforts to bring about a complete reversal of the present AMA position were attempted through a resolution which would urge revision of state laws so that abortion would be available upon demand. Recognizing that there is a tendency throughout the country to liberalize abortion laws, it was nevertheless noted that in those states such as Georgia where liberalization has taken place, the law follows very closely the present policy of the AMA, and it was therefore reaffirmed.

Planning and Development

What is perhaps the most far-reaching and controversial matter to come before the AMA House of Delegates is the Report of the Committee on Planning and Development. This report offers 18 groups of recommendations totaling 57 specific actions. A Minority Report contains an additional 19 recommendations and suggests many more. The Report represents the result of study concerning the long range objectives of the AMA and the resources, programs and organizational structure by which the Association attempts to reach them.

It is also intended to serve as a focal point for the planning of activities of the Association and to stimulate and coordinate planning activities throughout the Association. The Committee was to study, or cause to be studied, medicine and the environment in which the Association must function and to transmit the conclusion of those studies, in the form of recommendations, to the Board of Trustees for distribution

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HIGHLIGHTS / Continued

to appropriate decision-making centers throughout the Association, particularly the House of Delegates.

Some of the recommendations of the Committee, such as abolition of such time-honored concepts as "fee-for-service" and "private practice" were greeted with unconcealed opposition. The House determined that a special body be designated to hold this report until the next Annual meeting and to receive and compile the many actions which this report will generate from the constituent states.

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THE MONTH IN WASHINGTON

A Senate subcommittee said that the number of medical malpractice suits probably will increase and "the situation threatens to become a national crisis."

Sen. Abraham Ribicoff (D., La.), chairman of the Subcommittee on Executive Reorganization which has been reviewing the federal role in the nation's health care problems for nearly two years, reported eight conclusions after an extensive staff study. They are:

"1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgments and settlements is increasing rapidly.

"2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of a deterioration of the traditional physician-patient relationship.

"3. The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other States. The situation threatens to become a national crisis.

"4. Already, higher judgments and settlements are having the following direct results:

(a) Companies providing malpractice insurance are increasing the cost of coverage.

(b) These costs—in the form of higher charges—are being passed on to patients, their health care insurance companies, and federal health care programs.

Defensive Medicine

"5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury.

"6. At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.

"7. The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to

the legal community.

"8. There is a definite federal role in the malpractice problem."

Specialists listed as having "a greater potential exposure to malpractice suits" were orthopedic surgeons, general surgeons, neurosurgeons, anesthesiologists, obstetricians and gynecologists.

The 1150-page report included responses from staff inquiries to the American Medical Association, the American Hospital Association, lawyers and malpractice insurance companies.

Possible Consideration

If the situation continues to worsen, the report said, the federal government "may have to consider . . . a reinsurance pool to which it would contribute."

If the federal government moves into the malpractice area, the report said, it also should consider:

" . . . whether medical or surgical injury to a patient is a community responsibility and therefore compensable by the community.

" . . . whether it must provide legal aid to the poor to help them seek redress from personal medical or surgical injury.

" . . . whether it will insist upon creation of more effective regulatory devices over health professionals and health facilities to assure that those who are providing care are competent to do so."

Recommendation

A special task force recommended that the federal government experiment in different ways of paying physicians under medicare and medicaid.

In the first of a series of reports on medicaid, the task force—appointed by Health, Education and Welfare Secretary Robert H. Finch last July—said:

"HEW should actively program experiments for incentive reimbursement under medicare and medicaid, with new emphasis on experiments in payment methods for physicians as the key generators of health services. In addition to experiments in institutional reimbursement, other experiments could emphasize compensation to groups of practitioners using modified approaches to capitation with built-in controls on quality and costs."

JOURNAL
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Physician Manpower in Georgia...See page 43

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Contents

*See page 69 for the 116th MAG Annual Session
Motel Reservation Form*

Scientific Articles

PHYSICIAN MANPOWER IN GEORGIA Georgia Office of Comprehensive Health Planning	43
PRIMARY MYOCARDIAL DISEASE: CLINICAL CHARACTERISTICS Nanette Kass Wenger, M.D., and Gerald F. Fletcher, M.D.	60
THE POTENTIAL FOR REDUCING THE RISK ASSOCIATION WITH ELEVATED BLOOD LIPIDS R. B. McGandy, M.D., and F. J. Stare, M.D.	62

Special Articles

COORDINATED HOSPITAL STAFF-COUNTY MEDICAL SOCIETY MEETINGS William E. Huger, Jr., M.D.	50
THE CENTRAL ROLE OF THE HOSPITAL IN COMMUNITY HEALTH SERVICES Anne R. Somers	54

Editorials

VIRAL VALVULITIS	70
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Features

Heart Page	72
President's Letter	76
Legal Page	74
Month in Washington	79

The Association

New Members	78
Societies	78
Personals	78
Calendar	49

Cover

Designed by Marie Seaman.

Physician Manpower in Georgia

GEORGIA OFFICE OF COMPREHENSIVE HEALTH PLANNING, *Atlanta*

A SPECIAL TASK FORCE recently studied the state's present physician manpower situation and made recommendations regarding it. Key questions to which answers were sought by the task force in its study and deliberations included these: Will Georgia have sufficient numbers of physicians by 1975 or by 1985? In what ways can non-physician health personnel help extend physician productivity and services? What is the distribution pattern of patient-care physicians in Georgia? Are there sufficient physician services available to meet increasing demands for such services in the state? How can medical care be made more accessible to the socially and economically disadvantaged of Georgia's population?

Predominantly a physician group, the eight-member task force was formed early in 1968 by the advisory council to the Georgia Office of Comprehensive Health Planning. The staff of the office, directed by Dr. Eugene J. Gillespie, coordinated the work of the task force and provided research and other technical support.

Dr. Thomas J. Anderson, chairman of the advisory council and a practicing internist in Atlanta, named Dr. William W. Moore, Jr., an Atlanta neurosurgeon to serve as chairman of the task force. In addition to Dr. Moore, who was one of three representatives of the Medical Association of Georgia, the task force was comprised of: Louis C. Brown, M.D., Georgia State Medical Association; H. Harper Butterworth, Jr., M.D., Medical Association of Georgia; Harry B. O'Rear, M.D., president, Medical College of Georgia; J. W. Pinkston, Jr., administrator, Grady Memorial Hospital; Arthur P. Richardson, M.D., dean, Emory University School of Medicine; George L. Simpson, Jr., Ph.D., chancellor,

University System of Georgia; and Joseph S. Wilson, M.D., Medical Association of Georgia.

A study of the state's physician supply was deemed necessary because of the medical profession's central role in making comprehensive care available to all of Georgia's people. It is also one of the major health professions in the state which has not been the subject of recent study. The task force met five times following its appointment and gave careful consideration to the state's physician manpower situation. It studied data gathered by the Office of Comprehensive Health Planning from such sources as the American Medical Association, U.S. Public Health Service, Georgia Department of Public Health, Emory University School of Medicine, and Medical College of Georgia. Selected findings and the full recommendations of the task force report are presented here.

Principal Findings

The physician shortage is one of several important aspects of a growing national health care crisis. Despite greater numbers of health workers and medical facilities than ever before, widespread discontent with the costs and unavailability of professional health services has grown in recent years. This problem is far more than one of "numbers," as the rate of increase in the number of physicians has exceeded the rate of increase in population. In fact, demand for medical services has expanded dramatically, as awareness of the importance of, and ability to purchase, preventive and curative care becomes more widespread.

The physician shortage is evident in Georgia as well as in the nation. And, as in the rest of the country, the manpower shortage is becoming more critical even while the state experiences rapid economic growth and its citizens become more affluent.

Georgia's population, which has recently in-

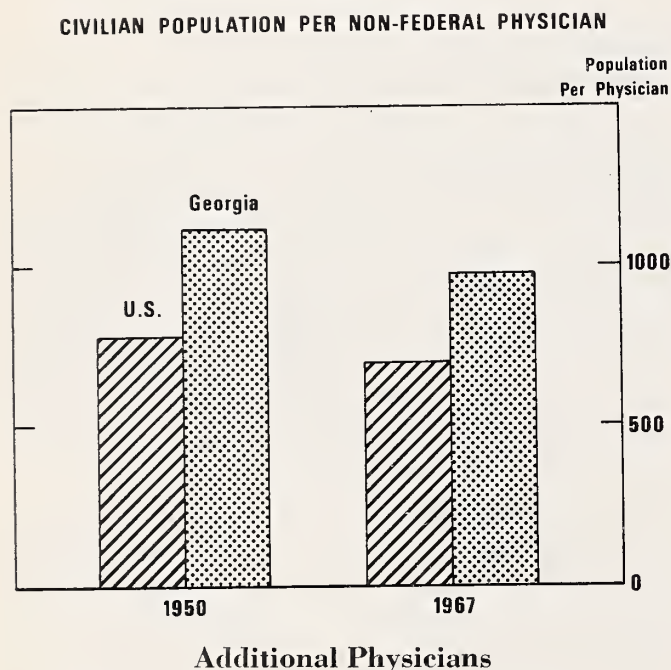
* This paper is a summary of a report entitled "Task Force: Physician Manpower in Georgia" which was compiled and printed by the Office of Comprehensive Health Planning, Georgia Department of Public Health.

MANPOWER SURVEY

creased at a faster rate than that of the nation as a whole, is expected to continue its growth, reaching a level of almost five million people by 1975. The 1968 population estimated by the Bureau of the Census was 4,568,000.

Expanding at a rate faster than the population, Georgia's supply of non-federal physicians numbered 4,636 in 1968. Although this gain during recent years has resulted in a slightly improved ratio of population per physician for the state, the Georgia physician still has a considerably larger proportion of the population to serve than does the average physician throughout the nation (Figure 1).

Figure 1



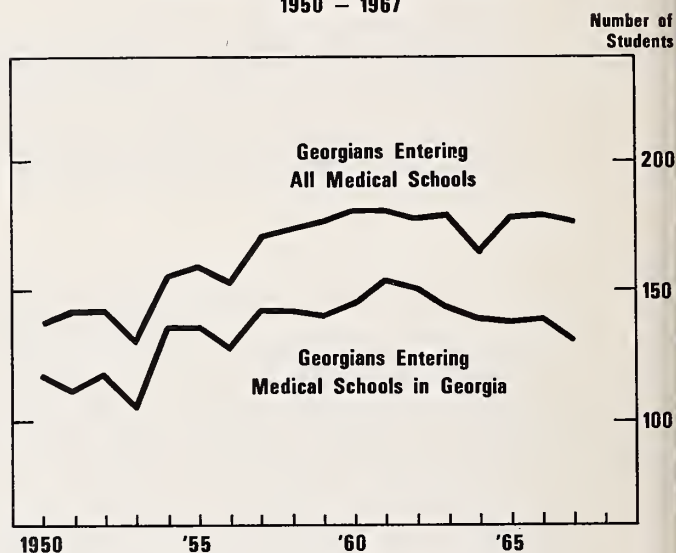
Georgia has a total of 5,247 physicians, half of whom are graduates of Georgia medical schools. Moreover, half of the 3,000 physicians who have graduated from the two medical schools over the past 20 years are currently residing in the state. Under present projected expansion of medical school enrollments in the state, 1,200 to 1,250 students might be expected to graduate between now and 1975. Assuming that the rate of retention will remain approximately the same as in recent years, it could be anticipated that, even taking military obligations into consideration, 600 to 650 physicians would be added to the state's supply by 1975.

The number of Georgians entering *all* medical schools increased irregularly during the period 1950 to 1960 before generally leveling off. This stabilization is contrasted to Georgia's increasing population. Moreover, Georgians beginning their medical training in Georgia medical schools paralleled this upward trend through 1961 when it peaked and

began a gradual downward movement. Two observations that can be made from these data for recent years are: 1) in relation to population, fewer Georgians have been entering all medical schools; and 2) more Georgians are beginning their medical training in out-of-state medical schools (Figure 2).

Figure 2

GEORGIANS ENTERING MEDICAL SCHOOL 1950 - 1967



Another important aspect concerns the rate at which Georgians applied and were admitted to medical school. In 1967-1969, approximately 1,100 Georgians applied for admission to the entering class of the state's only public school of medicine, the Medical College of Georgia at Augusta. Of these, slightly over 300 students, or about 100 each year, were admitted. Present facilities do not permit acceptance of all qualified applicants from Georgia.

Evident Need

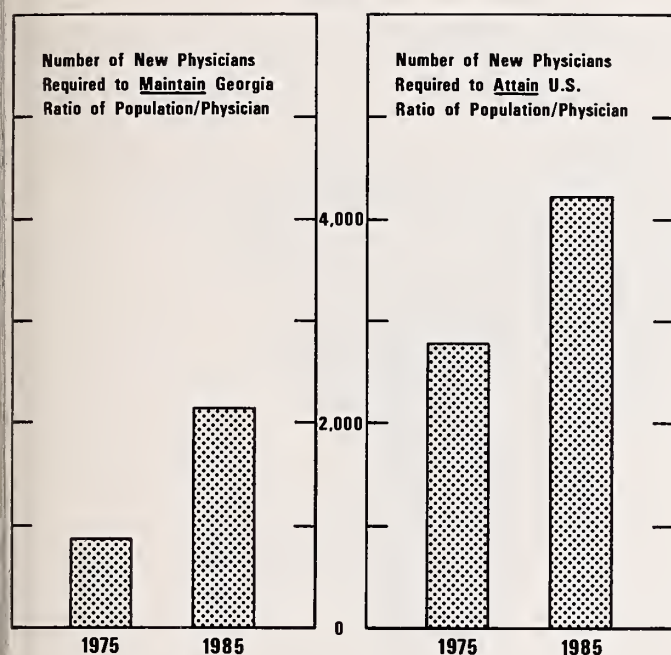
The need to expand the supply of physicians beyond current numbers is evident. However, the additional number necessary is difficult to determine. Even an adequate estimate may not be possible until significant improvements are made in the ways physicians are utilized.

Georgia's present ratio of population per physician compares unfavorably with the national ratio and with the ratios of two of her five neighboring states, Florida and Tennessee. To reach the current national average of population per physician, Georgia would need at the present time about 1,700 additional physicians.

In order to maintain the state's present relationship of population and physicians by 1975, Georgia must add an estimated 900 new physicians to its supply in the next six or seven years. If Georgia were to reach the 1967 national ratio of population per physician by 1975, it would require about

2,800 additional physicians, and by 1985, approximately 4,200 more physicians. These estimates are based on anticipated population growth and estimated mortality ratios among physicians (Figure 3).

Figure 3



Projected Growth

It is a generally accepted fact that for a number of reasons physicians, as do other professional people, tend to be drawn more to areas of large population concentrations. In light of this and because it is expected that Georgia's 1960 population will increase by over 30 per cent by 1975, it is important to view where this projected growth will be occurring.

In 1960, about 45 per cent of the state's population growth was concentrated in the 12 counties which comprise Georgia's six Standard Metropolitan Statistical Areas; that is, the metropolitan areas of Albany, Atlanta, Augusta, Columbus, Macon and Savannah. By 1975, about 2,650,000 people, or half of the state's citizens, are expected to reside in these 12 counties. Of the state's total projected increase from 1960 to 1975, these 12 counties will experience two-thirds of the gain. The anticipated growth in the Atlanta SMSA alone will account for almost 45 per cent of the state's total increase. The remaining 33 per cent of the expected population increase from 1960 to 1975 will be distributed over the non-metropolitan counties with some counties experiencing a decline in population.

Problems associated with the uneven distribution of physician care services can be expected to persist in the future with a continued general polarization of the population and physicians to large urban

centers. Such problems, unless significant changes occur, will continue to be acutely felt by the disadvantaged and the isolated.

Selected Characteristics of Present Supply

As of November, 1968, Georgia had 5,247 physicians including residents and interns. Excluding a small percentage who are no longer professionally active, the great majority are engaged in offering patient-care services through the private practice of medicine. Medical school faculties and other related activities accounted for less than 10 per cent of the total group (Table I).

TABLE I
PROFESSIONAL ACTIVITY OF ALL GEORGIA PHYSICIANS
November 1968

	Number	Per Cent of Total*
Total	5,247	100.0
Patient Care		
Private Practice	3,165	60.3
Interns	172	3.3
Residents and Fellows	579	11.0
Full-Time Hospital Staff	701	13.4
	4,617	88.0
Medically Related Activities		
Medical School Faculty	203	3.9
Administrative Medicine	70	1.3
Laboratory Medicine	34	0.6
Preventive Medicine	130	2.5
Research	43	0.8
	480	9.1
Inactive		
Retired	127	2.4
Other Inactive	23	0.4
	150	2.9

* Parts may not add to totals due to rounding.

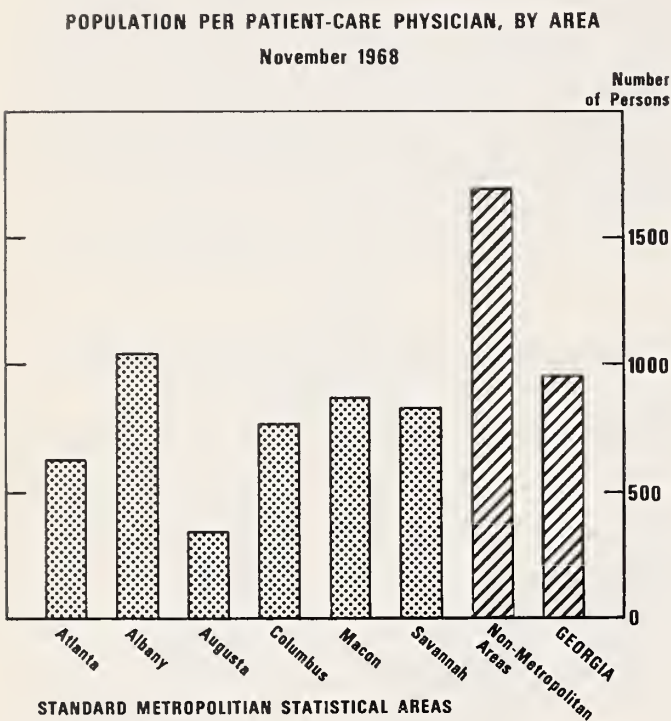
The 5,097 *active* physicians are unevenly distributed throughout the state. Whereas the six major metropolitan areas of the state comprise nearly half of the civilian population, 72 per cent of the active physicians are located in these areas. A more significant revelation is that 46 per cent of the active physicians live in the Atlanta Metropolitan Area, where 29 per cent of the state's civilian population resides.

Twelve of Georgia's 159 counties contain nearly 47 per cent of the state's total population. These dozen counties comprise Georgia's six major metropolitan areas, within which resides 70 per cent of the total number of patient-care physicians in the state. In these six areas, there is an average of one patient-care physician per 639 persons. This is con-

MANPOWER SURVEY

trasted to a ratio of one patient-care physician per 1,689 persons for the total non-metropolitan counties. (Figure 4.)

Figure 4



As of December, 1967, Georgia's patient-care physicians hypothetically bore a population load more than 40 per cent greater than the average load for physicians throughout the United States. (Table II.)

TABLE II

POPULATION PER PATIENT-CARE PHYSICIAN, BY STATE

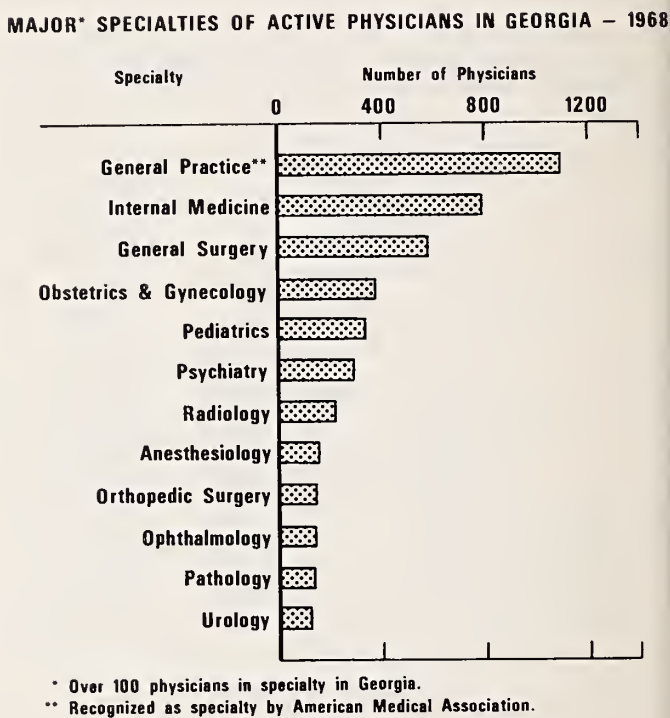
December 1967

	Population Per Patient-Care Physician
United States	794
Alabama	1,352
Florida	856
GEORGIA	1,118
North Carolina	1,122
South Carolina	1,364
Tennessee	986

Much of the concentration of specialties in metropolitan areas reflects two major trends—a tendency of heavy population centers to attract newly-trained physicians and a trend towards specialization and away from general practice. For instance, presently about one-fifth of all physicians in the state are in general practice. Ten years ago, approximately one-third were in general practice. Present intra-state

figures for patient-care physicians show a strong concentration of specialists in the metropolitan areas while the non-metropolitan counties have approximately as many specialists as general practitioners (Figure 5).

Figure 5



The average age of all active physicians is 43.8 years. Metropolitan physicians have a mean age of 42.0 years, which is 6.4 years younger than their non-metropolitan counterparts.

Ninety-five per cent of Georgia physicians are males.

It is estimated that there are fewer than 100 Negro physicians in Georgia, most of whom reside in the Atlanta area.

Collectively, the three most prevalent practice areas—general practice, internal medicine, and general surgery—account for 48 per cent of all specialists.

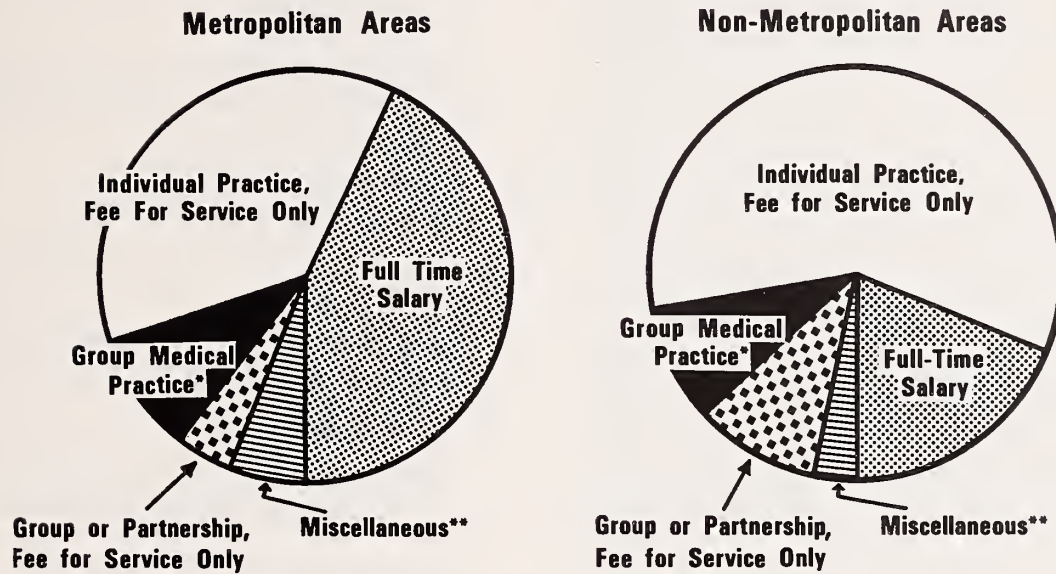
Almost 60 per cent of the state's active physicians are self-employed. Beyond the category of self-employed, substantial numbers of the medical profession throughout the state are employed by non-federal hospitals (18 per cent) and the federal government (12 per cent) while medical schools employ 5 per cent of the state total.

Over half of the non-metropolitan physicians' professional income is derived from individual practices on a "fee for service only" basis. However, in the six metropolitan areas, the dominant source of income is from "full time salary." An interesting observation was that an equal percentage of non-metropolitan physicians, as metropolitan physicians

Figure 6

PHYSICIANS' MAJOR SOURCES OF PROFESSIONAL INCOME

November 1968



* See narrative for definition.

** Includes individuals, groups and partnerships, with various combinations of fee for service and salary as income source.

(9 per cent), reported "group medical practice" as their source of professional income (Figure 6).

Georgia's medical schools have graduated 2,615—about half—of the total number of physicians residing in the state. Of these, Medical College of Georgia has graduated about 56 per cent and Emory has graduated 42 per cent. Sixty-four of the state's physicians are graduates of Georgia medical schools that are no longer in existence. Medical schools in the five states touching Georgia have graduated 13 per cent of the total supply, while all other medical schools, including foreign, have graduated 37 per cent.

Sixty-three of Georgia's 78 osteopaths were in private practice.

Task Force Recommendations

Each task force recommendation was made to contribute to the attainment of three broad goals, which were to improve the use of the physicians Georgia has, to train more physicians, and to institute measures that will make more physicians want to live and practice medicine in Georgia's communities. All the recommendations help to focus appropriate attention on the need to assure all Georgians greater availability of professional medical care in the years that lie ahead.

Recommendations to Improve the Utilization of Existing Physicians

1. A series of purposeful forums should be held at the state and local levels to examine specific, proven measures for making the best use of physicians' time, and to encourage adoption by physicians of those measures deemed suitable and productive. Such forums should be organized by and for persons knowledgeable in actual conditions of medical practice and administrative management and should focus on:

(a) considering additional areas of practice that could properly become physician-directed instead of physician-performed. For example, what duties of a routine and time-consuming nature, now performed wholly or in part by physicians, can safely be delegated to each of several existing types of properly trained allied health personnel?

(b) discussing how auxiliary personnel, now unavailable or very scarce, could be used advantageously in offices and hospitals if and when such persons are trained and available.

2. Programs should be supported to increase the supply of trained allied medical personnel of the

MANPOWER SURVEY

types and levels of training found to be most needed.

3. Hospital policies should be studied with a view to promoting more efficient use of physicians' time. For example, compulsory meetings, required committee work, and record keeping could be appraised.

4. Exploration should be made of possibilities for increasing total productivity of physicians and conserving their time by improving communications, transportation and locational patterns. Such possibilities would include developing networks of consultative relationships between communities, hospitals and medical centers, improving communications, and reducing transit time between hospitals and physicians' offices. The planning of new medical care centers should promote the clustering of offices around a clinic, hospital, or other central facility. Consultative relationship plus reduction in time and distance barriers could reduce the individual physician's on-call (for emergencies) hours and benefit patients as well.

5. Study should be made of current utilization of physicians by type of practice and specialty and the extent to which innovations, such as various types of group practice, should be endorsed and promoted.

6. Support should be given to health education programs that prepare consumers of health services for more intelligent participation in health care. The content of such programs should emphasize preventive care, the uses and limitations of medical self-help and the roles of various types of allied health personnel in the medical care system. Special emphasis should be placed on providing such health information to the disadvantaged.

7. The development of community referral systems should be promoted to assist the rational entry of consumers into the health care system.

8. A complete picture should be developed and maintained of: the demand for and supply of allied health personnel; existing paramedical training programs and courses; the relationship of training center locations to areas most in need of paramedical services; and the effect of state licensing requirements on availability and distribution of paramedical personnel.

9. Methods should be devised for upgrading paramedical disciplines by enlarging the scope of their responsibilities.

10. Physicians should be encouraged to employ the "team approach"—effectively utilizing paramedical personnel—and should be assisted in selecting the kinds of arrangements best suited to their particular practices and communities.

11. Medical schools should be encouraged to

include training in the use of paramedical personnel in their curricula.

Recommendations to Increase Medical School Enrollments

1. A study should be initiated at the earliest possible date to consider:

(a) the maximum feasible expansion of existing medical schools, including possible tax support of private institutions;

(b) the feasibility of developing a two-year medical school; and

(c) the feasibility of establishing a four-year medical school.

2. Specific opportunities should be developed to provide for the education of more black medical students.

Recommendations to Attract, Retain and Allocate Physician Manpower

1. An organized recruitment program for attracting physicians now in training or in practice out of the state should be developed.

2. Licensure requirements should be reviewed to determine whether any may inhibit the in-migration of qualified physicians.

3. Factors affecting the demand for and availability of interns and residents should be identified, and methods should be devised for improving the current ratio of supply to demand.

4. A survey should be conducted to identify factors that influence physicians' choices of communities in which to practice and assess the relative importance of each locational factor.

5. Full support should be given to public or private programs which are designed to stimulate civic progress such as the Georgia Certified City Program, in order to make more Georgia communities attractive to physicians.

6. Particular attention should be given to making physician services and physician-directed services more accessible to the disadvantaged and to those living in isolated areas, by:

(a) encouraging more physicians to practice among the poor, through special scholarships to medical students and through other incentive programs;

(b) promoting neighborhood health center expansion in low-income areas, to be conducted under the auspices of organizations and institutions such as medical schools and medical societies;

(c) including field work in neighborhood health centers or other projects for the disadvantaged

as part of the basic education of medical students and allied health care personnel;

(d) alleviating the transportation problems of low-income patients; and

(e) having communities provide medical facilities to permit and attract physicians to practice in their area (part time or full time).

Upon the presentation of its report and conclusion of its functions as an ad hoc committee, the task

force requested the Georgia Comprehensive Health Planning Council to suggest means by which the task force recommendations may be implemented by appropriate groups and organizations. In its July, 1969 meeting the council accepted the task force's report and began immediately to consider the recommendations' implications and to advise the State Health Department on their implementation.

1280 W. Peachtree Street

CALENDAR OF MEETINGS

In Georgia

March 8-10—Atlanta Graduate Medical Assembly, Marriott Motor Hotel, Atlanta.

March 15-19—Society of Toxicology, Marriott Motor Hotel, Atlanta.

March 16-18—Post-Graduate Course in Team Approach to Arthritis and Rheumatic Diseases, Grady Memorial Hospital, Atlanta.

April 19-23—Southeastern Surgical Congress, Marriott Motor Hotel, Atlanta.

In the Nation

March 1-6—American Radium Society, Hotel Del Coronado, San Diego, Calif.

March 2-4—Clinical Concepts in Infectious Disease: Manifestations and Management, University of Florida College of Medicine, Gainesville, Fla.

March 2-5—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La.

March 5-8—Federation of Western Societies of Neurological Science, Del Webb Towne House, Phoenix, Ariz.

March 6-7—Committee on Maternal and Child Care—Regional Conference, Marriott Motor Hotel, Chicago, Ill.

March 6-8—Committee on Nursing with its Panel of Nurse Consultants, Ponte Vedra Club, Ponte Vedra, Fla.

March 7-8—Society of University Otolaryngologists, Hilton Hotel, Portland, Ore.

March 7-11—California Medical Association, Hilton Hotel, San Francisco, Calif.

March 8-10—American Association of Pathologists and Bacteriologists, Chase-Park Plaza Hotel, St. Louis, Mo.

March 9-12—AMA Board of Trustees, Marco Polo Hotel, Daytona Beach, Fla.

March 9-13—Cardiovascular and Renal Disease: Pathophysiology and Pharmacology, Presbyterian-St. Luke's Hospital, Chicago, Ill.

March 10-14—International Academy of Pathology, Chase-Park Plaza Hotel, St. Louis, Mo.

March 12—Council on Mental Health, Drake Hotel, Chicago, Ill.

March 12-14—Southern Society of Anesthesiologists, Williamsburg Lodge, Williamsburg, Va.

March 13-15—Council on Legislative Activities, Washington, D.C.

March 14-18—American Society of Abdominal Surgeons, Clinical Congress, Deauville Hotel, Miami Beach, Fla.

March 15-19—International Anesthesia Research, Caesar's Palace, Las Vegas, Nev.

March 15-21—North American Clinical Dermatologic Society, Mountain Shadows, Scottsdale, Ariz.

March 16-18—American College of Surgeons, Sectional Joint Meeting for Doctors and Nurses, Washington, D.C.

March 16-20—American College of Allergists, Americana Hotel, Bal Harbour, Fla.

March 16-20—Clinical Problems in Internal Medicine, Cleveland Clinic, Cleveland, Ohio.

March 18-20—Post-Graduate Course and Annual Scientific Meeting of the American Fertility Society, Washington-Hilton Hotel, Washington, D.C.

March 19—A Day of Cardiac Pathology with Jesse E. Edwards, M.D., University of Florida College of Medicine, Gainesville, Fla.

March 19-24—American Dermatological Association, Boca Raton Hotel, Boca Raton, Fla.

March 20—Residency Review Committee for Psychiatry and Neurology, DuPont Plaza Hotel, Washington, D.C.

March 20-21—AMA National Congress on Socio-Economics of Health Care, Palmer House, Chicago, Ill.

March 20-21—Society for Clinical Ecology, Americana Hotel, Bal Harbour, Fla.

March 20-22—American Psychosomatic Society, Washington-Hilton Hotel, Washington, D.C.

March 22—Editorial Board, Archives of Dermatology, Boca Raton, Fla.

March 23-25—Association for the Advancement of Medical Instrumentation, Boston, Mass.

March 23-26—American Orthopsychiatric Association, Mark Hopkins and Fairmont Hotels, San Francisco, Calif.

March 23-26—Neurology and the Internist, Mayo Clinic and Mayo Graduate School of Medicine, Rochester, Minn.

March 24—Conference on Tubercular and Other Respiratory Diseases, Waldorf-Astoria Hotel, New York.

March 25-26—Symposium for Physicians Practicing General Medicine, Los Angeles, Calif.

March 25-28—Neurosurgical Society of America, Ojai Valley, Calif.

March 26-27—Committee on Aerospace Medicine, NASA Headquarters, Houston, Tex.

March 30-April 3—Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment, The University of Michigan Medical Center, Ann Arbor, Mich.

March 30-April 4—American College of Radiology, Statler-Hilton Hotel, Dallas, Tex.

Coordinated Hospital Staff-County Medical Society Meetings

WILLIAM E. HUGER, JR., M.D., *Atlanta*

WHY COORDINATE? The best reason for coordinated effort in a medical community was summed up by the 1964 Attendance Report of the Medical Societies' Executive Association which states:

"Required hospital meetings have destroyed or are destroying the county medical societies with the aid or assistance of such groups as specialized societies. There are still too many competing medical meetings. Coordination is needed. Physicians will attend meetings which are definitely beneficial to them individually or in which they feel they play an active role, rather than a captive audience. Meetings must be easy to reach, pleasant, stimulating, well-organized, efficiently run, start and end on time, and give each physician a sense of participating in the rewarding experience. Medical societies, specialty groups and hospitals must cooperate in coordinating their meetings and program planning if they are to accomplish their objectives."

Therefore, the idea of coordinating hospital staffs with medical society meetings is not a new one as evidenced by the 1965 AMA Survey of County Medical Society Activities in which it is reported that 30 per cent of the societies combine their meetings with local hospital staff meetings. Admittedly, the majority of these societies referred to are small groups with one hospital involved, although some involved over 1,500 members and many hospitals.

History

The growth of Atlanta in the years since World War II has outstripped its medical efficiency. The influx of doctors and para-medical personnel has been somewhat consistent with the growth, but the utili-

zation of existing facilities has spread professional personnel throughout the metropolitan area. Often "the right hand has not known what the left hand was doing." No one person could speak with authority for the majority. Medicine's activities involving the local medical society, the hospitals and paramedical groups, and the individual doctors themselves, needed coordination.

It was recognized at the outset that the Fulton County Medical Society, being the central society in this area and the largest of those involved, should be the focal point of activity. Its headquarters at the Academy of Medicine building is also centrally located. It was further recognized that certain of the peripheral hospitals were the primary function units for other county medical societies and that the University Hospital, as well as certain small specialty hospitals located on the margin of these peripheral areas, probably would not, or should not be involved in any efforts of centralized activity. This estimate has proven correct—although future participation by all of these units may be desirable.

In 1951 a Committee of the Fulton County Medical Society recommended that hospital departmental (or sectional) meetings and society scientific meetings be combined. In 1955 a well worked-out plan was submitted to the Joint Commission on Accreditation of Hospitals. Sanction by that organization was denied. Variations of this proposal were again denied in 1960 and 1965. In 1967 we became aware of the successful 1962 attempt by the Dade County Medical Society, in Miami, Florida, to accomplish on a smaller scale the same objectives as we. By correspondence and personal visits, we investigated the activities of that society and have leaned very heavily on their experience as the pioneer in this field.

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In July 1967, two representatives of our Society met with the Director of the Joint Commission on Accreditation of Hospitals in Chicago. We presented to him at that time a plan utilizing the hospital general staff meetings rather than the departmental meetings, coordinated with the Fulton County Medical Society meetings. On that basis, we were successful in obtaining from the Joint Commission a letter of approval for our Plan.

Following approval by our Society, each hospital general staff was approached through its chief and at the same time the administrators of all metropolitan hospitals were approached through their organization, the Atlanta Hospital Council. With the exception of those units previously mentioned, one by one the major hospital staffs and the Atlanta Hospital Council approved our plan.

Ad Hoc Committee

In February 1968 a newly formed Ad Hoc Committee met. The committee was composed of one representative from each participating hospital and one representative from the Fulton County Medical Society—all having the same single vote. It was decided to proceed with our plan and a general meeting schedule in some detail was worked out. Each delegate then took the proposed plan back to his next general hospital staff meeting for approval. At the same time, the plan was presented to and approved by the membership of the Fulton County Medical Society.

In April 1968, a second Ad Hoc Committee meeting was held. It was voted to begin our Plan in July 1968 and to include the pharmaceutical industry. The second Tuesday of the month was selected as meeting time because this would allow hospital administrators to get statistical information on the preceding month's activities to their staff prior to meeting time. Again, each delegate took the recommendation back to their general hospital staff meeting for approval.

By May 1968, everyone involved knew hospital staff and medical society meetings were going to be coordinated. The exact schedule and mechanism was not generally known, however. We will emphasize, at this point, that we consider of extreme importance our having taken the hospital administrators into our confidence at the very first. They have proved to be a cooperative group. They are singularly interested in the welfare of their hospitals and of any help to the physicians which, in turn, would aid him in responding to the hospital programs.

Informing the Medical Community

July 9, 1968, the second Tuesday of the month was the target date. Means of advising all parties

concerned about the proposed changes took several forms. The June issue of the Fulton County Medical Society Bulletin carried information advising the members of the coming general changes. On June 20 a Fact Sheet was distributed by Fulton County Medical Society in an all-member mailing and to the hospital administrators. It spelled out the particulars of the Plan with regard to which hospitals would meet each month during the forthcoming year and where and when the hospital meetings would be held.

On July 1, the July issue of the Fulton County Medical Society Bulletin highlighted the proposed program. Included were a copy of the letter of approval from the Joint Commission on Accreditation of Hospitals, a notice of the encouragement given us by the AMA House of Delegates, and a copy of the Fact Sheet in detail.

On July 2, each hospital scheduled for meetings on July 9 notified its staff as to the change of meeting date, time, and place.

On July 2, the medical society sent to its members its usual meeting notice, but in the form of a new double post card. Included was the time and date schedule of hospital meetings in the Academy of Medicine building, on July 9.

Pharmaceutical Industry Participation

Discussions with the pharmaceutical group began in April of 1968. At that time a meeting was held between representatives of the Society and the representatives of five drug companies. Through these meetings, we derived our approach to the pharmaceutical industry. In May 1968 a meeting was held with approximately 30 pharmaceutical "Regional Managers." From this meeting evolved the basic "ground rules" for pharmaceutical industry participation. Each company was invited to participate on a mutually beneficial basis in two ways. First as a Sponsor, for which we asked each participating company to contribute \$100 per year. This money is currently committed to a Continuing Education Fund drawn upon by the Program Committee as needed for lectureship honoraria and expenses. We estimated a \$3,000 per year need and are happy to report that the 31 drug companies approached for 1969 all participated. The list of sponsoring companies is displayed at the entrance to the Auditorium at each meeting.

The second means of participation is as Exhibitor. Four to six drug companies supply table top exhibits at each monthly meeting. A list of exhibiting companies is displayed at the entrance to the exhibit hall, with stars indicating which companies participate in a given month. This activity is considered of

mutual benefit so that no display charge is made to the companies.

It should be noted that the drug industry's various budget meetings are held primarily in September and in January of each year. For this reason, the ground rules were distributed to the companies involved in August and several Progress Reports sent out in November and December. A final list of sponsoring companies and the final Exhibit Schedule was distributed in January, 1969.

Medical Society Responsibility

Each month the Society's responsibility is only a little more than before. On the first of the month the Bulletin carries the meeting schedule. Then on the second of the month the notice cards go out. The program and hospital staff meetings are listed on one portion of the card. A second portion is marked for dinner reservations and returned to the Society office. On the 15th of the month the drug company scheduled to exhibit the following month is so notified by form letter.

Result to Date

On July 9, 1968, our first Coordinated Meeting was held. Dinner was served between 5:30 and 7:30 by a caterer under contract. One group of hospitals met between 6:00 and 6:45 in three meeting rooms in the building. The same facilities were utilized for another group of hospitals between 6:45 and 7:30. The medical society business meeting was held and limited to the half hour between 7:30 and 8:00 and the society scientific program was presented between 8:00 and 9:00. Since that date the same format has been followed.

The problems anticipated have not materialized. The hospital administrators have, between themselves, arranged for adequate attendance by any doctor who is on the staff of more than one hospital. There has not been a hue and cry raised by those oral surgeons, dentists, and paramedical personnel who need to come to the Academy of Medicine for their hospital staff meetings. They are invited to eat and remain for the FCMS meeting if they so wish. The hospital staff meeting time of 45 minutes should probably be cut to about 30 minutes. We need more space for exhibitors. Many companies who have already exhibited, have requested a second exhibit opportunity this year. How we can satisfy them, I do not know.

Our overall Society meeting attendance increased approximately 65 per cent. We have sold 30 per cent more meal tickets for the coming year than for last year. Many doctors have commented on how

nice it is to see colleagues from other parts of town whom they do not see otherwise. It appears that doctors are making a conscientious attempt to visit pharmaceutical exhibits. The representatives have commented that they are seeing doctors that they ordinarily do not see and are seeing doctors they ordinarily have difficulty in getting in to see on office calls. In short, there appeared to be some rather strong tangible and intangible benefits which seem to outweigh any current drawbacks.

What of the Future

In July, 1969, the Ad Hoc Committee again met. At that time, we were to decide whether to continue our program and, if so, what changes to incorporate. Many variations can be played on the same theme. It is generally agreed that a really significant reduction in the number of meetings which a doctor must attend will not be fully achieved until departmental (or sectional) meetings are in some way coordinated within the ruling of the Joint Commission on Accreditation of Hospitals. It is our thought that all hospital departmental meetings might coordinate with the general staff meetings in a staggered fashion on the second Monday, Tuesday, and Wednesday of each month. In this way, excepting Specialty meetings, most meeting obligations would be complete in a period of three days. It would be a radical change—but for the rest of the month, each doctor would be left with more time to devote to his patients and to his family. In the long run, it should mean better patient care and longer self-survival, which certainly would make the change a worthwhile effort. A proposed schedule is yet to be completed.

If adequate exhibit facilities become available, we would certainly like to increase the number of monthly exhibitors to include office, medical, surgical, and communication equipment suppliers. If a growing Continuing Education Fund could be maintained, then we will be in a position to call in prominent speakers. In this way, we could anticipate a continued attendance increase, and an increased exposure between the doctors and the exhibitors. Paramedical groups—such as nurses, technicians, office personnel, and students, whom we need so badly to sell on careers in medicine and allied professions, could be intermittently included in some way. We would hope to develop a complete cycle of continued growth together.

Individual Cooperation

Why should we personally cooperate with a coordinated program? Medicine has been traditionally made up of individuals respectful of one another, skeptical of new ideas, and suspicious of organiza-

tional efforts. Many of us are in solo practice. We, therefore, rebel from organized medicine, but that is why we now have our government intruding more and more in medicine. Medicare and Medicaid are here. We cannot look the other way and pretend that they will disappear. We cannot successfully fight individually. We must now cooperate and coor-

dinate in order to individually survive. Only then will our medical community regain its once strong respected voice through which the individual doctor can in turn have an effective and respected voice in the affairs of his own environment.

1938 Peachtree Rd., N.W.

AUTHOR'S NOTE: *At the end of the first year of our coordinated meeting program one hospital withdrew. It is a peripheral hospital with a staff partially drawn from even more geographically distant areas. Thusly the inconveniences involved leading to withdrawal were anticipated.*

On November 18, 1969 a meeting of the Ad Hoc Committee was held. The interpretation of the new Standards of the Joint Commission on Accreditation of Hospitals, which allows coordination of departmental (or sectional) meetings, was discussed. Four primary recommendations were made to the participating hos-

pitals and the Society: (1) That the coordinated meeting program be continued. (2) That hospital staff meeting time be reduced to thirty minutes by adjusting the schedule toward the Society business session at 7:30 P.M. (3) That the meeting schedule allow each hospital to substitute an "Annual Meeting" at the hospital. (4) That no attempt be made at present to coordinate the departmental (or sectional) meetings in order that the program be allowed to mature and stabilize without further confusion.

These recommendations have been properly reported and the meetings schedule times adjusted.

Be assured, that no man can know his own profession perfectly, who knows nothing else; and that he who aspires to eminence in any particular science, must first acquire the habit of philosophizing on matters of science in general.

—Abraham Colles

CALL FOR SCIENTIFIC EXHIBITS

116TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Jekyll Island, Georgia, May 7-10, 1970

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The Central Role of the Hospital in Community Health Services

ANNE R. SOMERS,* *Princeton, N.J.*

THIS IS A SUBJECT both difficult and complex, all the more so because the phrases "central role of the hospital" and "community health services" have become part of the "conventional wisdom" of the medical care field. But like those other deceptively simple concepts such as "comprehensive care," or the "changing doctor-patient relationship," they have never been given precise content or meaning. In a sense this is inevitable and a tribute to their broad appeal. But for those who are charged with responsibility for bringing these concepts to life, for putting them into effect, it is essential that some degree of consensus be achieved as to what we are talking about.

What I would like to do today is to present for your consideration a model of this central hospital role as I see it evolving over the past two decades and through the coming decade of the '70's—a purely theoretical model and one projected several years into the future—but one that I hope may help to clarify some of the many seemingly contradictory trends. Needless to say, I will welcome—and expect to get—your critical comments.

The Model

The hospital of the mid-'70's will be the central coordinating force—the organizational hub—of the entire system of community health services. When I say hospital I mean all the elements in that complex institution—the trustees, the medical staff, the administration, the nursing service, etc. By community health services I mean all the professionally controlled services provided to substantial numbers of people in what may be called the mainstream of care and regardless of whether they are financed primarily on a public or private basis.

This does not mean that all such services will be

physically provided within the hospital. On the contrary, the community health system of the future will not only require fewer hospital beds, per capita, than at present but will stress physical decentralization for all services except those that actually require sophisticated technological equipment and highly specialized personnel. There will be increasing emphasis on neighborhood health centers—and these, I believe, will be located in affluent as well as underprivileged neighborhoods—on private group practice clinics, on first-aid stations in isolated localities, on good long-term care facilities, home health services, etc.

It does mean that the hospital—as the broadest-based source of authority, in terms of professional, technological, and financial resources, the site where professional needs and values and community needs and values meet and can be reconciled—will be assigned responsibility for assuring the essential functional and organizational relationships and the necessary qualitative and quantitative controls to make the whole complex system of community health services work on a predominantly voluntary basis.

What do these words mean in practice? Obviously, in a country of this size and wide regional and cultural variations, they will mean different things in different places. But, at the risk of great oversimplification, here are two illustrations. I am assuming throughout this discussion an evolutionary development, with all this implies in terms of some continuant irrationalities, rather than a drastic revolutionary overhauling of our present non-system—an overhauling that might well lose more than it would gain.

Mercy Community Hospital

Mercy is a typical community hospital of the mid-'70's, one of six serving a highly urbanized city of about 500,000, which I will call Urbanton.

* Research Associate, Industrial Relations Section, Princeton University. This paper was presented as the first Distinguished Guest Lecture in Hospital Administration at Georgia State University, Atlanta, March 27, 1969.

Urbanton does not really need six hospitals. Four would be quite adequate and more in line with the national trend to fewer, larger, institutions. However, until 1971, there were seven separate hospitals in this community and the reduction to six, by merger of two, represents progress.

Mercy has about 350 beds, a first-class* surgical service, an intensive-care unit, a coronary unit, and a renal dialysis unit. The department of ambulatory services includes most of the usual specialty clinics, a physical rehabilitation service, a geriatric clinic emphasizing psychiatric services, a well-developed social service, a small but excellent emergency service, and a first-class primary care unit. There are no inpatient, pediatric, or maternity services.

In addition to these central facilities, Mercy operates a 200-bed extended care facility and, just a few blocks away, two neighborhood health centers—one and three miles from the hospital, respectively, and an extensive home health service. It has referral agreements with two additional ECF's, several nursing homes, and a community mental health center.

Most of its nonprofessional services—laundry, food services, housekeeping, business operations—and even some of the professional—most of the routine laboratory work for example—are provided through a multi-hospital corporation contracting with the six hospitals.

Medical Staff

The medical staff consists of approximately 150 physicians, about 50 of whom are full-time. These include the medical director, director of medical education, director of community medicine, chiefs of all the major services, the radiology, pathology, anesthesiology, physical medicine, and psychiatry departments *in toto*, the staffs of the emergency room, primary care unit, and the two satellite neighborhood health centers.

Most of the doctors have their offices in the medical arts building next door to the hospital and owned by it. The largest suite is occupied by the Mercy Medical Group—a separate organization of 35 physicians. The rest of the building is occupied by doctors in various degrees of combination, mostly two-or-three-man partnerships. Nearly all, except for the obstetricians and pediatricians, have their primary affiliation with Mercy, although many have joint appointments in other hospitals as well.

Mercy is not a teaching hospital in the sense that it has undergraduate medical students. However, it is affiliated with Metropolitan University Hospital, about 50 miles away. Thanks to this affiliation, it has an organized referral system for the super-specialties, the benefit of easy consultation with the

staff of University Hospital, and close working relations with respect to its residency program. This affiliation, plus the hospital's vastly increased interest in community medicine, have enabled it to obtain a majority of U.S.-trained house staff for the past few years, a situation that never prevailed in the '60's.

Patient Population

Mercy's patient population is still not defined as precisely as some planners would like to see. Nevertheless, a pretty clear *de facto* service area has gradually emerged, particularly as a result of clearer identification of the community's primary care doctors with a single institution. Since all the hospitals do not provide all services, however, there is necessarily some crossing of geographical boundaries.

This latter policy was hotly debated for several years. There were community leaders as well as doctors who felt that every hospital should have a maternity and pediatric service, a cobalt unit, dialysis unit, an emergency room, in general the whole gamut of hospital services. But eventually those who favored a policy of partial institutional specialization prevailed. Mercy reluctantly gave up its inpatient pediatric and maternity services in return for recognized preeminence in geriatric services and the only dialysis unit in Urbanton. It continues to provide ambulatory, pediatric and maternity services through its department of community health, but patients with serious illness requiring hospital admission are referred to the Good Neighbor Hospital which is only a few miles away and whose facilities and staff have specialized in these services. As a corollary, Mercy's dialysis unit and geriatric clinic serve the entire community.

Today, three years after the somewhat traumatic realignment of programs, both physicians and community appear generally pleased with the results. Clearly, better services are being provided at less cost than would otherwise have been the case. In the late '60's, Mercy's OB service was running an occupancy of about one-third, Good Neighbor about 50 per cent. Today, the latter's OB rate averages close to 80 per cent—about as high as a maternity service can be expected to operate effectively.

High Costs

Costs at Mercy are not low. Hospital costs have continued to rise nationwide, but it is hard to compare them with the experience of the '60's since the crude and meaningless *per diem* measure was abandoned several years ago by the AHA and the BLS now prices a number of other hospital services in addition to the inpatient room rate. The

average all-inclusive room rate at Mercy is now \$125 a day.

Fortunately, methods of financing care have also continued to develop so that this high price is virtually never borne by an individual patient at the time of illness. Despite continuing pressure for extending Medicare to the entire population, this has still not been done, chiefly because private insurers and hospitals are now seriously working together in the effort to develop new techniques of spreading the costs, bringing in government financing at many points but retaining voluntary initiative in design and operation of the programs.

The more affluent of Mercy's patients continue to rely on traditional types of insurance, especially the combination of basic hospital coverage and major medical. Under these plans, physicians are still paid on a fee-for-service basis. The majority of patients, however, are now covered by a new type of prepayment plan, modelled somewhat after the Kaiser Foundation Health Plan, on the West Coast, and now sold by a number of plans in other parts of the country. Under this scheme, Mercy Hospital and its medical staff provide plan subscribers with all necessary medical care for a flat monthly fee. The plan acts as fiscal intermediary for a number of groups, including most of the major union health and welfare funds, a number of the principal employers in the area, Medicare, and the welfare department for Medicaid patients.

So far as medical services are involved, some—for example those in the neighborhood health centers—are provided by salaried doctors; for others the hospital contracts with the Mercy Medical Group. Inpatient maternity and pediatric services and highly specialized services such as open heart or brain surgery are purchased by Mercy on behalf of these patients from other institutions with which it has referral agreements.

The financial arrangements are complicated and far more expensive than if provided under a single national Medicare plan. However, they are clearly in line with the traditional preference of the providers of care in the U.S. for pluralistic financing, no matter how complicated, rather than outright government operation. In any case, the institution of a capitation approach to payment for hospital and medical costs and their integration into a single program have helped considerably to make doctors more cost-conscious, to force hospitals to greater managerial efficiency, and generally to restrain the rise in costs to bearable dimensions.

Metropolitan University Hospital is one of the nation's hundred best and largest teaching hospitals, the primary teaching arm of a first-rate medical school. With 800 beds it has virtually every major specialty and superspecialty. It also has a large and active department of community and family medicine which is largely responsible for administering the network of affiliations with community hospitals and other community health facilities and programs.

Like Mercy, it also has an active ambulatory service and several neighborhood health centers. Unlike at Mercy, however, these are operated primarily as research, teaching, and demonstration units. They are relatively small and deliberately focused on the most difficult patient populations within reasonable access. For example, one center is located in a skid row area where drug addiction and alcoholism, combined with multiple socioeconomic problems, present University's Department of Community Medicine and Department of Drug and Alcohol Studies with abundant "teaching material" while providing the inhabitants of this area with as good care as can be found anywhere in the country. Patient care for this grossly atypical population is heavily subsidized by a new Institute of Community Medicine in the NIH.

The ambulatory center in University Hospital itself seeks to present students and faculty with a typical cross-section of the population. The number it serves, however, is deliberately restricted to a number that can be dealt with at the inevitably slower pace required for academic patient care. The costs are paid in the same way as at Mercy—partly by traditional insurance, partly by capitation plans, but in all cases with an educational subsidy. Thus the carriers and subscribers are not charged the extra cost of academic care. The patient population is largely self-selected and comes from a relatively large area of the metropolis.

University's residents and interns, as well as graduate students in public health and hospital administration, are rotated among several of the affiliated community hospitals, like Mercy. This is especially true of those who are specializing in community or family medicine. Conversely, residents from the community hospitals come into University at frequent intervals for conferences, grand rounds, and once a year for a two-week residency. The interchange between house staff faculty in the two types of institutions has been enriching to both and has improved the total quality of patient care available in the entire area.

Primary Care Facilities

To complete the picture, one would have to give similar vignettes illustrating the organization and work of institutions that are smaller and less sophisticated professionally than Mercy Hospital. Depending on the cultural and physical geography of the area and region this might be a small rural hospital, a neighborhood health center in a large urban area, a private group practice clinic, an emergency first-aid station in a sparsely populated region or in a seasonal resort area (whose primary facility might be a helicopter or Piper cub), a college infirmary, a small industrial hospital in the mining or lumbering fields, or any number of other types of primary care units where emergency services must be provided on a standby basis but where the chief requirement in any serious situation is quick transfer to a fully equipped hospital.

The diversity of such institutions and lack of time precludes doing justice to this echelon of the developing health care system. It should be clear, however, that the organization, staffing, and financing of such services are a vitally important link in the total picture if all Americans are to be provided with good medical care. The time for wishful thinking that we can persuade good young doctors to move into such areas on a solo basis is already long past. By the mid-'70's, let us hope, all efforts will be concentrated on linking these primary outposts of care to our urban hospital system. Let us also hope that the urban hospitals will rise to the challenge of assuming responsibility for these units by developing mutually-beneficial satellite agreements.

Principal Barriers

The Chinese have a saying to the effect that it is easier to paint a dragon than a horse. Many of you are undoubtedly saying that it is much easier to paint these glowing pictures of non-existent Mercy and University Hospitals than it would be to work out the immediate problems in real life institutions. Of course you are right. No one today can be so naive as to think anything approaching such a community, regional, and ultimately national system of health services can be achieved without overcoming numerous difficulties and probably without having to live through some pretty rough battles and many temporary set-backs.

Let me try to identify some of the major barriers as I see them.

First, and perhaps most obvious, is the fact that very few hospitals in the U.S. have geographically defined service boundaries. Indeed, many hospitals, especially in multi-hospital urban areas, do not

really know what their service area is, or the size of the population they serve, or other elementary facts essential to rational planning and programming.

Whether we will eventually reach a stage where hospital districts are defined as precisely as school districts, I am not sure. I am not even sure I would want to see it. More important than 100 per cent geographical precision is a sense of commitment to a specific community or a portion of a community. And I do feel sure that, as the costs of hospital care continue to rise, we will move generally in this direction. If hospitals do not get together and make at least some informal service area agreements among themselves, it will be forced on them from outside.

Problem of Financing

Second, the problem of financing is of course formidable and is perhaps the major obstacle cited by most hospital spokesmen for failure to move further in the direction of comprehensive service, especially ambulatory. No one knows what the ultimate solution to this problem will be. The easiest way out—especially in the short run—would be to turn the whole problem over to government through the extension of Medicare to the whole population. This will be, I suspect, a real temptation, not only to the public which doesn't much care how the financing is arranged, provided the direct costs are not too great and they are not related to a means test, but also to the providers and carriers who may find the Medicare route appealingly simple compared to the problems and headaches of pluralistic financing. Nevertheless, I still believe that new and ingenious efforts will be made to keep the financing primarily private. In my picture of Mercy Hospital in 1975, I have suggested one way that this could be done.

Even more difficult than the problem of financing is the problem of hospital-physician relations. In the words of the new Catholic Hospital Association's policy statement on comprehensive care, "The hospital administration-medical staff interface will be the site of maximum strain during this period of health service development."

This is a problem that I dealt with at some length in a rather widely publicized article that appeared in Part 2 of the *Journal of Medical Education*, January, 1965—the proceedings of one of the Association of American Medical Colleges Teaching Institutes. The article had an impossible title that I can't even recall myself, but it dealt with the conflict between Dr. Jones, a conscientious hospital-based specialist, and Dr. Smith, an equally conscientious community-based G.P. I concluded—even

seven years ago—that time, history, and the progress of medical science and technology were on the side of Dr. Jones. I still believe this and think that developments of the past few years have demonstrated the correctness of this position.

Minority Preference

But I also believe that there will be—at least for the foreseeable future—a substantial minority of both doctors and patients who will continue to prefer a noninstitutional setting for as much of their medical care as is possible. And I see no reason why this minority preference cannot be combined with the majority trend to institutional practice. This, it seems to me, is one of the advantages of the hospital as principal coordinator of care. Coordination does not mean swallowing up. It does not even mean physical integration. As already noted in the definition of our model, it means primarily functional and organizational relationships. And there is no technical reason—there will be political and human resistances—why the hospital cannot exercise the same qualitative and quantitative controls over its attending staff for work done in their private offices as it now exercises them for work done on the hospital premises.

With the development of computers, it would be entirely possible to plug each physician—even the die-hard soloist—into the hospital record-keeping and retrieval system, thus overcoming one of the principal shortcomings of solo practice while retaining the very real advantages of decentralized primary care.

Fourth, is the problem of authority. Where is the hospital going to get the power to do things I have been talking about? No one knows just how this is going to evolve. But there can be no doubt that the American people are going to move toward some form of “system” in the delivery and financing of health care. This system could be predominantly governmental, it could be imposed through some giant profit-oriented corporation (for example, some of the companies in the aerospace industry), or it could come about under the leadership of the existing voluntary hospitals. These, I believe, are the only possible alternatives. Personally, I prefer the latter. With all its shortcomings, I guess I feel a little like Hamlet who preferred to “. . . bear those ills we have/Than fly to others that we know not of.”

Achieve Systemization

If the hospitals and their boards and medical staffs can pull themselves together to move reso-

lutely and aggressively enough in the next few years, I think the necessary degree of systemization can be achieved on a voluntary pluralistic basis, with a minimum of statutory compulsion applied at certain essential strategic points. For example, the major thrust of the important Barr Committee Report* recommends that effective hospital planning can and should be done primarily by voluntary planning bodies but with ultimate authority in a state body which in turn derives strength and power from its relation to federal funding. In other words, the strength of government is applied to make sure that the voluntary bodies accept their responsibilities and do their job but it does not do the job for them. Unless, of course, they abdicate and refuse to do the job themselves.

Similarly, with respect to physician-hospital relations, standards of physician competence, conduct, and performance should be set and enforced by peer groups based in the hospitals. The authority of government should be used only to make sure that all physicians are in fact subject to some such peer group control and that the hospitals are in fact exercising such controls in a responsible and accountable manner. Thus, I would favor compulsory affiliation of all physicians with a hospital as a condition of continued licensure.

This combination of public and private responsibility constitutes, in my view, pluralism at its best. I believe the U.S. Congress and most state legislatures would happily do their part to see to it that the hospitals are given the necessary authority if only the hospitals are willing to take on the job. Remember, again, when I say “hospital” I mean the entire institution including, most especially, the medical staff.

Lack of Vision

Finally, and in my view, the biggest of all barriers to achievement of the model is lack of vision. I agree completely that designing a theoretical model is no substitute for developing a real hospital or a real hospital system. Nevertheless, the opposite fallacy is just as bad. The world is full of good souls who simply cannot conceive of a world free of war, or free of poverty, or racial prejudice, or where medical care is provided on the basis of a rational cooperative system. Perhaps, I should even add where hospital administrators, boards, and medical staff work cooperatively together for the common good!

“I have a dream,” said Martin Luther King and he was correct in knowing where to start. “If you don’t have a dream,” said Bloody Mary to the

* U.S. Dept. of Health, Education, and Welfare, Secretary's Advisory Committee on Hospital Effectiveness, Report, 1968.

young lovers in South Pacific, "How you gonna make a dream come true?" Or, as it is said in the Old Testament, "Without vision, the people perish." My guess is that the biggest single obstacle to achievement of the national health care system outlined here is the general lack of conception that it is possible or what the system might look like even if all the obstacles were removed.

Signs of Progress

I have deliberately emphasized the obstacles because, like most pragmatists, I hate nothing worse than to be accused of wishful thinking or starry-eyed idealism. Nevertheless, as I look about the national hospital scene, it seems to me there are some significant portents of progress.

I think, for example, of the many hospitals in New Jersey, often alleged to be one of the backward states in this respect, that have recently added full-time directors of medical education, that have recently staffed their emergency rooms on a full-time basis, and that are now applying for grants, or otherwise seriously considering establishing first-class, one-class, ambulatory services in place of their traditional indigent clinics.

I think, for example, of the many neighborhood health centers that have been established throughout the country in the past two to three years. While some of these are free-standing, organizationally as well as physically (a fact that I regret), I have no doubt that eventually nearly all of them will become satellites of hospitals.

I think, for example, of the progress of hospital planning, progress that has been temporarily confused and in some places set back by the apparently contradictory philosophy and experience of the two new planning bills 89-749 and 89-239. But this is progress which, almost surely, will be resumed simply because there is no other way to deal with costs short of direct government control.

I think, for example, of the American Hospital Association's courageous effort to write planning

and planning sanctions into the hospital reimbursement formula. I think, for example, of the significant CHA Policy Statement on Comprehensive Care, already referred to, with its strong emphasis on the role of the hospital.

Finally, and most important of all, I think of the hundreds, perhaps thousands, of individual hospitals—big and small, community and university, open staff and closed staff, rich and poor—across the country that are at this moment exploring ways in which they can relate more effectively to their communities, ways in which they can provide better medical care more efficiently to their communities, and ways in which they can relate more effectively to the physicians and other health professionals in their communities. From a Michael Reese with its \$35 million annual budget, its medical staff of 500, and its 3,000 employees, to thousands of small community institutions, hospital administrators, trustees, and medical staff are asking themselves these questions and seeking answers.

To help them find their answers is, I take it, the major purpose of these programs in hospital administration. Of course, you will be expected to master all the elements of administration in the technical sense. But, increasingly, the definition of good management today is the "engineering of change." If you plan to become a top hospital executive in the future, I think you will have to master this most difficult and challenging of all arts. It won't be an easy job. It is not for the timid or the overly conservative. Nor, for that matter, is it for the extreme radical. You can't hope to improve an institution—hospital, university, or any other—by destroying it.

In concluding, I would like to offer one word of advice which I take from another well-known American institution. I refer to the Playboy Club of Chicago which, I am told, has the following motto engraved over its entrance: "Si non oscillas, noli tintinari."

Translated into the vernacular, this means: "Man, if you can't swing, don't ring!"

Princeton University

It can be said that each civilization has a pattern of disease peculiar to it. The pattern of disease is an expression of the response of man to his total environment (physical, biological, and social); this response is, therefore, determined by anything that affects man himself or his environment.

—Rene J. Dubos

A study of 34 patients is summarized.

Primary Myocardial Disease: Clinical Characteristics*

NANETTE KASS WENGER, M.D., *Atlanta, and*
GERALD F. FLETCHER, M.D., *San Diego, Calif.*

IN A RECENT STUDY of 34 patients with the clinical diagnosis of primary myocardial disease, we found no serologic evidence to implicate viral infections, parasitic infections, or a number of immunologic responses as etiologic of this disease.^{1, 2} This report delineates the clinical characteristics of these 34 patients.

Criteria for the diagnosis of primary myocardial disease included: 1) No clinical evidence of atherosclerotic, rheumatic, congenital, metabolic, hypertensive, infectious, toxic, infiltrative, neuromuscular, or familial myocardial disease; 2) No evidence of collagen disease, pregnancy, or the immediate postpartum state (8-10 weeks); 3) No evidence of endocardial fibroelastosis, endomyocardial fibrosis, hypertrophic muscular outflow tract obstruction, hypersensitivity, or traumatic myocardial injury; 4) History of or the presence of congestive heart failure or cardiac enlargement.

At the current evaluation, these 34 patients varied in age from 21 to 80 years, with an average age of 51 years. Twenty-two of the patients were female, 12 were male; 29 were Negroes and five were white. Their duration of disease varied from a minimum of eight months to a maximum of 250 months, with an average disease duration of 87 months.

Alcoholic Intake

An alcoholic intake varying from total abstinence to average social drinking was reported in two-thirds of the patients; one-third of the patients were excessive social drinkers or severe alcoholics. There

was no apparent correlation between the reported alcohol consumption and the clinical symptoms.

The most prominent and constant symptoms were weakness or fatigue, exertional dyspnea, orthopnea, and paroxysmal nocturnal dyspnea, which occurred in three-fourths of the patients. One-third of the patients had experienced chest pain at some time, but only occasional patients reported either palpitations or hemoptysis.

Three-fourths of the patients were normotensive; sustained diastolic hypertension of greater than 100-110 mg Hg was not encountered. Twenty patients had apical systolic murmurs which were usually holosystolic, and seven had systolic murmurs along the left sternal border, some of which were described as ejection in character. One patient had only the murmur of tricuspid insufficiency. Six patients had no murmurs. One patient had the murmur of tricuspid insufficiency in addition to an apical systolic murmur, and two patients with systolic murmurs also had blowing diastolic murmurs along the left sternal border.

Cardiac Enlargement

Cardiac enlargement was clinically demonstrable in all patients and was confirmed by x-ray examination. The radiologic description was predominantly of biventricular hypertrophy with a few patients reported as having only left ventricular hypertrophy. Only two patients had a normal apex impulse to palpation; in 21, the abnormal apex impulse was that of left ventricular hypertrophy and in 11 was compatible with biventricular hypertrophy.

Two-thirds of the patients had abnormal deep jugular venous distension, an S-3 gallop, hepatomegaly, and peripheral edema; pleural effusion and

* From the Department of Medicine, Emory University School of Medicine, and the Medical Service and Cardiac Clinics, Grady Memorial Hospital, Atlanta, Georgia.

pulmonary edema had been present at some time. Ascites, pulsus alternans and an S-4 gallop were uncommon and usually occurred together in the patient with severe cardiac decompensation. Pericardial effusion was recognized in only one patient, in whom it recurred several times.

Pulmonary embolization occurred in about half of the patients, but only one episode of systemic embolization was encountered. Disturbances of cardiac rhythm were encountered in about one-half of the patients, with premature ventricular beats and atrial fibrillation being most common. Three patients had sustained sinus tachycardia.

Abnormalities

Two-thirds of the patients had nonspecific ST-T electrocardiographic abnormalities and either increased QRS voltage or characteristic changes of left ventricular hypertrophy. One-half of the patients had either left axis deviation or an abnormality of intraventricular conduction. One-half of the patients with sinus rhythm had abnormal P waves.

Thirty of the 34 patients had been treated with digitalis and diuretic agents; 10 had received antiarrhythmic agents, usually quinidine, on a chronic basis. Seven patients had had a trial of prolonged bed rest and seven had been treated with long term anticoagulant drugs, usually coumadin.

Twelve patients had died at the time of this report and they had characteristically died suddenly and unexpectedly at home. Postmortem examination was performed in three patients; the cardiac diagnosis at autopsy was primary myocardial disease.

It is often a cause of astonishment that men with quite ordinary, even vulgar, natures experience no fear of death. But it is quite explicable: it is not the fear of death which creates the desire for immortality, but the desire for immortality which causes fear of death.

Summary

Weakness, fatigue, exertional dyspnea, orthopnea, and paroxysmal nocturnal dyspnea were the most prominent symptoms in 34 patients with primary myocardial disease. Chest pain, palpitations and hemoptysis were not common. Most patients were normotensive. Systolic murmurs, often holosystolic, were heard both at the cardiac apex and along the left sternal border. Cardiac enlargement was constant, and was described as biventricular hypertrophy on radiologic examination. The abnormal apex impulse was compatible with left ventricular hypertrophy. Most patients had evidence of biventricular congestive heart failure, often with pleural effusion and pulmonary edema. Ascites, pulsus alternans, and pericardial effusion were rare. Pulmonary embolization had occurred in about one half of the patients, but systemic embolization was unusual. Over one-half of the patients had disturbances of cardiac rhythm, usually premature ventricular beats or atrial fibrillation. Most patients had nonspecific ST-T electrocardiographic abnormalities and the pattern of left ventricular hypertrophy. There was no apparent correlation between reported alcoholic intake and the clinical signs or symptoms. Death was characteristically sudden and unexpected.

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—Otto Weininger

AMA APPOINTS STAFF MEMBER TO STRENGTHEN SAMA LIAISON

Liaison between the Student American Medical Association and the American Medical Association staff will be the responsibility of the editor of *American Medical News*, Marvin L. Rowlands.

The appointment was made by Ernest B. Howard, M.D., executive vice president of the AMA.

Rowlands' assignment will supplement the work of the liaison committee of the AMA Board of Trustees. Irvin E. Hendryson, M.D., Albuquerque, N.M., who is vice chairman of the AMA Board, serves as chairman of its SAMA liaison committee.

"I have asked that greater emphasis be placed on liaison between SAMA and the AMA staff," Doctor Howard said. "Marvin Rowlands has been directed to coordinate efforts of the AMA staff to provide every possible assistance which SAMA members and staff request."

Doctor Howard emphasized that the AMA staff recognizes the autonomy of SAMA, but said that the AMA can offer many supporting services to assist the medical students' organization.

Most of us consume an atherogenic diet, so that essentially the entire adult population has levels of cholesterol and triglyceride which must be interpreted as "abnormal" by world-wide standards.

The Potential for Reducing the Risk Associated With Elevated Blood Lipids

R. B. MCGANDY, M.D., and F. J. STARE, M.D., *Boston, Mass.*

OF THE SEVERAL FACTORS associated with accelerated development of atherosclerosis and with an increased risk of coronary and cerebrovascular disease, elevated blood lipids have received special attention for several reasons:

1. Diet and circulating lipids have been historically involved in the modern knowledge of atherosclerosis and its clinical complications both in laboratory animals and in man;

2. Blood lipids associated with atherosclerotic disease are importantly influenced by diet;

3. Of the various risk factors involved with our contemporary way of life, decreases in the circulating lipids are readily possible via dietary changes and easier to achieve than is alteration in other factors. The dietary approach lends itself to possibly successful primary prevention programs at the community level;

4. Furthermore, and most important, there is the potential for building many of the important dietary alterations into the foods themselves. This must await leadership on the part of various regulatory agencies and the food industry itself.

While it may seem reasonable to assume that dietary changes leading to reduced levels of circulating lipids would potentially lead to less atherosclerosis and to less risk of complications, there is so far only suggestive, indirect, and minimal direct support for such an assumption. We do not yet have conclusive and adequate direct evidence from human studies that dietary manipulations will do this. Definitive studies to answer the question will be expensive and time-consuming; they have unfortu-

nately not even been launched. Thus, there may be no certainty one way or the other for another decade, but the possible rewards in better health in the prime of adult life for many are tremendous.

Role of Diet

The role of diet in the prevention or management of coronary heart disease has become a contemporary medical controversy, a controversy primarily between those who are interested in diagnosis, monitoring, treatment, and "new hearts," and those who are interested in prevention, in keeping well the heart one has. The clinicians and surgeons have been and are definitely in the lead in capturing the interest and dollars of the public. It would be of interest to speculate, or to know, the dollars appropriated for studies of the treatment of cardiovascular disease versus its prevention. The differences would be pretty huge even though the latter potentially has far more to offer the vast majority of mankind.

Medical recommendations cannot be and are not always based upon certainties. The epidemic of atherosclerotic vascular diseases continues unabated; there is really no evidence that any presently available medical therapy can significantly reduce morbidity or mortality. Thus, management and preventive efforts must be based on rational probabilities.

We believe that there is a compelling body of evidence supporting the concept of dietary changes for the management, and especially for the prevention of these diseases. Such changes are safe, effective in their influence on circulating lipids, and very much simpler to achieve than most clinicians realize.

Management versus Prevention

The extent and severity of atherosclerosis in the United States population from adolescence onward,^{1, 2} the high risk of clinical sequelae—especially coronary heart disease—even among men in their 40's and 50's,³⁻⁷ the facts that almost one-third of first manifestations of coronary heart disease culminate in sudden death⁸ and that survivors of an initial event are at an increased risk of subsequent episodes,⁸ all provide a persuasive argument for a preventive approach, ideally commencing in early life. Dietary or other therapeutic management of individuals who already have clinical evidence of coronary heart disease may be a good deal less hopeful than preventing or retarding the underlying atherosclerosis in the first place. For, on the whole, such individuals have more extensive atherosclerosis and may have ischemic, scarred tissue in areas which predispose to easy triggering of fatal arrhythmias. On the other hand, their limited prognosis presents compelling reasons for attempting any possible therapeutic measures.

Blood Lipids

Triglyceride, cholesterol, phospholipid, and fatty acids are not themselves soluble in water or plasma. They are transported in combination with protein and are categorized into four major classes. Chylomicrons synthesized in intestinal mucosa provide the major transport of absorbed dietary fats. The beta lipoproteins, for the most part synthesized in the liver, are the main carriers of fat in the fasting state. The non-esterified fatty acids ("NEFA") are a small but very rapidly turning over fraction of plasma fatty acids transported bound to albumin. The family of beta lipoproteins (complexes of triglyceride, cholesterol, and phospholipid wrapped in a carrier protein) is the lipid class most closely associated with atherosclerosis—both in man and in laboratory animals.

The measurements of total serum cholesterol and of fasting serum triglyceride provide useful though indirect estimates of the level of the beta lipoprotein family. On the whole, the levels of these two lipids are highly correlated with one another. In terms of their observed association with atherosclerotic vascular disease as studied in epidemiologic investigations, the one cannot be shown to be a significantly more powerful predictor of disease than the other.^{9, 10} On the other hand, knowledge of the levels of these two lipids alone is not sufficient for complete classification of the gross hyperlipidemias.¹¹ Among the 5 per cent or so of middle-aged individuals with a serum cholesterol level of 300 mg per cent or above or with a lactescent fast-

ing serum, determination of the electrophoretic or physical-chemical characteristics of the lipoproteins is important to their management, whether with diet, drugs or both.¹¹

For most individuals, serum cholesterol and fasting triglyceride determined accurately and on at least two or three separate samples of blood drawn one to a few days apart, will suffice for a base line to the follow-up assessment of management.

The Diet, Circulating Lipids and Atherogenesis

Over 50 years of studies with laboratory animals have shown that an elevation of circulating beta lipoproteins (reflected in an elevated level of cholesterol and triglyceride) is essential for the induction of atherosclerosis. In sub-human primates, species being extensively studied at present, an artery wall disease histologically quite similar to that found in man can be induced. But no matter what the species, feeding diets rich in saturated fats and/or cholesterol is the basic method of producing lesions. Though animal studies have advanced our understanding of the role of diet (through its influence on circulating lipids) on atherogenesis itself, they have not so far been developed as models of the clinical complications, that is infarction and arrhythmias as seen in man. This is an important area deserving more work.

One of the important lessons learned from animal studies concerns variability. Even under constant dietary and environmental conditions, there is considerable, unexplained variation in the response of circulating lipids and in the extent of induced atherosclerosis among animals of the same species. Thus, when studying man, where diet and way-of-life are not nearly so constant in a given population, and where the measured end point is not atherosclerosis but a superimposed often subjective clinical event, one ought not to be surprised by the very large variations between individuals. This greatly complicates uncovering mechanisms and associations. Moreover, it may well be that the appearance of clinical events (thrombosis, angina pectoris, etc.) is influenced by still other factors than those related to the underlying atherosclerosis.

The strong association between diseases whose expression is, in part, a gross elevation of circulating lipids and very premature atherosclerosis and coronary heart disease has been long recognized. Some of the familial hyperlipidemias, diabetes, untreated hypothyroidism are examples of this.

Epidemiologic studies, both national and international have consistently demonstrated the overall association between circulating lipoproteins (cholesterol, being the easiest to measure, has been

most often used) and the incidence rate of coronary heart disease. This has been discussed by Dr. Dawber. The association with thrombotic cerebrovascular and peripheral vascular disease is similar.^{12, 13} But other personal characteristics associated with an increased risk of clinical sequelae have also been identified:⁹ elevated blood pressure, exercise habits, obesity, heavy cigarette smoking, and perhaps others. It is very difficult, perhaps impossible, to parcel out the independent effect of each of these or to understand their interaction in observational studies on man. And there is no easy means for separating influences on atherosclerosis from influences affecting clinical events. Thus, atherosclerotic vascular disease is complicated and its appearance is determined by an array of host and environmental factors operating over a long time span. Though one can do pretty well at identifying groups^{4, 14} of individuals who are, on the average, at much greater risk of developing coronary heart disease than others, one is far from being able to quote precise statistical odds for any given individual, for any particular patient.

Although there is much we still do not know, this must not obscure what we do know. Atherosclerotic vascular diseases may not be inevitable, they may not be immutable concomitants of aging, their presence or progression may not be accounted for solely on the basis of genetic factors, but they certainly can be delayed or postponed by several years, and ameliorated when they do appear.

Levels of Circulating Lipids and the Influence of Diet

One of the real limitations in fully developing the relationship between diet, circulating lipids, and incidence rates of clinical vascular disease from epidemiologic studies carried out among middle-aged American populations, is that most of us consume an atherogenic diet and that essentially the entire adult population has levels of cholesterol and triglyceride which must be interpreted as "abnormal" by world-wide standards. The whole distribution spectrum of serum cholesterol levels is shifted upward in our middle-aged male population: 85 per cent of men have a level of 200 mg per cent or above, a level achieved by only a few males of the same age in areas of the world where atherosclerotic vascular diseases are rare. Furthermore, only our own and other affluent Northern European societies show this continuing upward shift from adolescence to middle age.²⁵ If one were to consider 200 mg per cent as the "safe" level of cholesterol, then 85 per cent of adult males in this country

would, theoretically at least, benefit from a lower level. As shown by Dr. Dawber and others, individuals with higher levels would benefit more.

Estimates of the potential reduction in risk which might be expected from a given reduction in the level of circulating cholesterol have been based on the relationship between cholesterol and incidence as described in various epidemiologic studies. The magnitude of this potential effect is considerable: for example, a 10 per cent reduction in serum cholesterol would be expected to yield a concomitant 20 to 25 per cent reduction in incidence of coronary heart disease. One does not know, of course, over what time period one could expect to show such an effect—over 20 or 30 years or in a five-year time span? Ultimately, however, it must make best sense to attack the problem of prevention not in middle-age but in the second decade of life, in adolescence, as it is during this period of active growth that cholesterol levels rapidly rise and that habit patterns of eating are firmly established. It is thought that in adolescence the underlying atherosclerosis usually begins its development in our population.

Many studies on man in which diet has been under close regulation have shown that certain changes, particularly in the fat composition of the diet, can account for the difference between distributions of cholesterol levels in various populations. For example, Antonis^{15, 16} found that after putting Europeans on a Bantu diet and vice versa, the distribution of serum lipids in time assumed the characteristics of those associated with the diet. This observation does not support the notion of a racial influence on serum lipid patterns. The problem is, of course, that the very low fat diets which characterize Bantu and other populations having little atherosclerotic heart disease are much too unpalatable and extreme for use in our society. But it is now known that the substitution of vegetable oils low in saturated fats and cholesterol and high in polyunsaturated fats in place of animal and dairy fats can achieve essentially the same effect on serum lipids. This has offered a way to maintain palatably high fat diets through the substitution of one kind of fat for another. Several controlled clinical trials have established the quantitative effects of saturated and polyunsaturated fats as well as of dietary cholesterol on serum cholesterol in man.^{17, 18}

Diet Determines Cholesterol Distribution

Thus, there is good evidence that diet accounts for the cholesterol distribution of our middle-aged male population being at a high range and we are all, in this sense, abnormal. But diet cannot account for the variability between individuals in a homogeneous population group—only the average levels.

When an individual at the high end of the distribution spectrum on a usual American diet is placed on a fat and cholesterol modified diet, he will achieve a significant reduction in serum cholesterol yet still be at the high end of the cholesterol distribution of individuals adhering to the same fat and cholesterol modified plan.

Field trials to test whether or not the dietary reduction of serum lipids can effectively reduce the risk of coronary heart disease, though ultimately indispensable, will be expensive and time consuming. The problem is not one of simply achieving and maintaining a reduction in serum cholesterol. Many studies^{19, 20, 26} have documented the feasibility of this. Long-term reductions of from 11 to 20 per cent (depending upon motivation and dietary adherence) have been achieved. The major problem is that a very large number of men will have to be observed over a four to six year period of time after their serum cholesterol has been lowered and kept lowered in order to document statistically the expected 25 to 40 per cent decrease in coronary attack rate. Ideally, of course, prevention of atherosclerosis should probably begin with adolescence.

Reports from primary prevention studies^{21, 22} and from studies commencing with survivors of an initial event^{23, 24, 27} have been encouraging. Yet none of them has been large enough to allow for conclusions with high statistical reliability.

Precisely the same problems outlined above beset therapeutic trials in areas other than diet: lipid-lowering drugs, physical activity, weight reduction, cessation of smoking, and so forth. The effectiveness of pharmacologic agents, recommendations aimed at environmental alterations other than diet, these too cannot now be based upon certainties.

Change from Food Industries

Lastly, and most importantly, we think the ultimate solution of this problem, that is, a change of diet in the direction of less total calories, less saturated fat and dietary cholesterol, and more polyunsaturated fats will come from the food industry itself. Most of our foods today are manufactured foods. This is necessary for many reasons in our growing urban populations. Tasty, pleasant, attractive, and nutritious foods—our usual foods—can be manufactured with the above principles built into them.

Food technologists have not been standing still. All types of meats and dairy products can be made with less saturated fat, less cholesterol, and more polyunsaturates. The same applies to shortening and margarines. With the latter we can have far less calories built into the final product, or perhaps we should say “built out.”

Tasty egg products with 80 per cent of the cholesterol and half the saturated fat that make delicious scrambled eggs or omelets are becoming available. Similar advances are possible with most of our foods.

But to bring these advances about the food industry must have some support and encouragement from our various governmental regulatory agencies, at both the Federal and State level, rather than the usual continued harassment or threat of harassment. I sometimes think that our regulatory agencies would do a better job for the consumer if they would dismiss half of their lawyers and replace them with competent and dedicated physicians and scientists.

If our governmental regulatory agencies do flash a green light to the food industry, it should insist that whenever a manufacturer points out the potential of his cake mix or ice cream, margarine or shortening in reducing the risk of heart attacks, he must also reiterate the need for observing *all* of what the American Heart Association and your heart association call the “risk factors” that contribute to heart disease—high blood pressure, overweight, lack of exercise, smoking and diabetes. This could produce the greatest public-health education campaign in the history of the country, and at no cost to the health agencies.

The result would be twofold. Millions of young people could look forward to longer, healthier lives. They also would be happier lives, because they and their children would be able to enjoy a more adventurous diet without anxieties. This, it seems to me, is eminently a cause worth striving for.

*Department of Nutrition
Harvard School of Public Health*

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A child . . . is the last container of a sense of humor, which disappears as he gets older and he laughs only according to the way the boss, society, politics or the race want him to. Then he becomes an adult. And an adult is an obsolete child.

—Theodor S. Geisel

“NEXT WITNESS” FILM SHOWS M.D.’S WHAT TO EXPECT ON WITNESS STAND

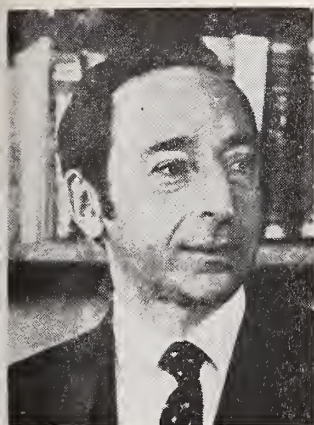
A new film, “Next Witness,” depicts to physicians what may be expected of them if called upon to be a medical witness in personal injury litigation. The film stresses the importance to both the physician and the attorney of pre-trial preparation for the medical witness; the story line shows how the lack of preparation could create awkward and embarrassing situations in court.

This new motion picture is of particular value to the

medical profession because about 70 per cent of all court action constitutes personal injury litigation, often requiring a physician’s testimony.

“Next Witness” is 16mm, sound-color and 29 minutes; it was produced by Vision Associates, Inc., to replace “The Medical Witness.” Prints are available on loan from the AMA Film Library, 535 North Dearborn Street, Chicago, Ill. 60610.

"FRONTIERS OF THE MIND" SET FOR SYMPOSIUM '70



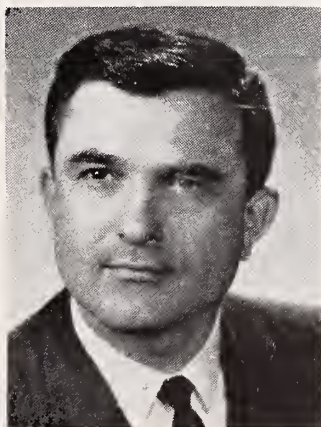
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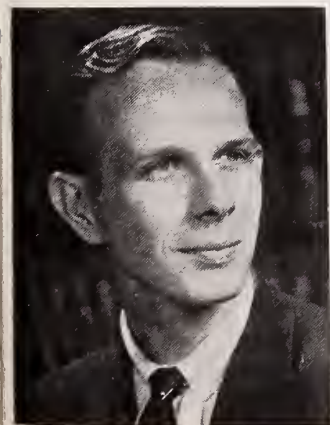
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**Allen E.
Smith, Ph.D.**



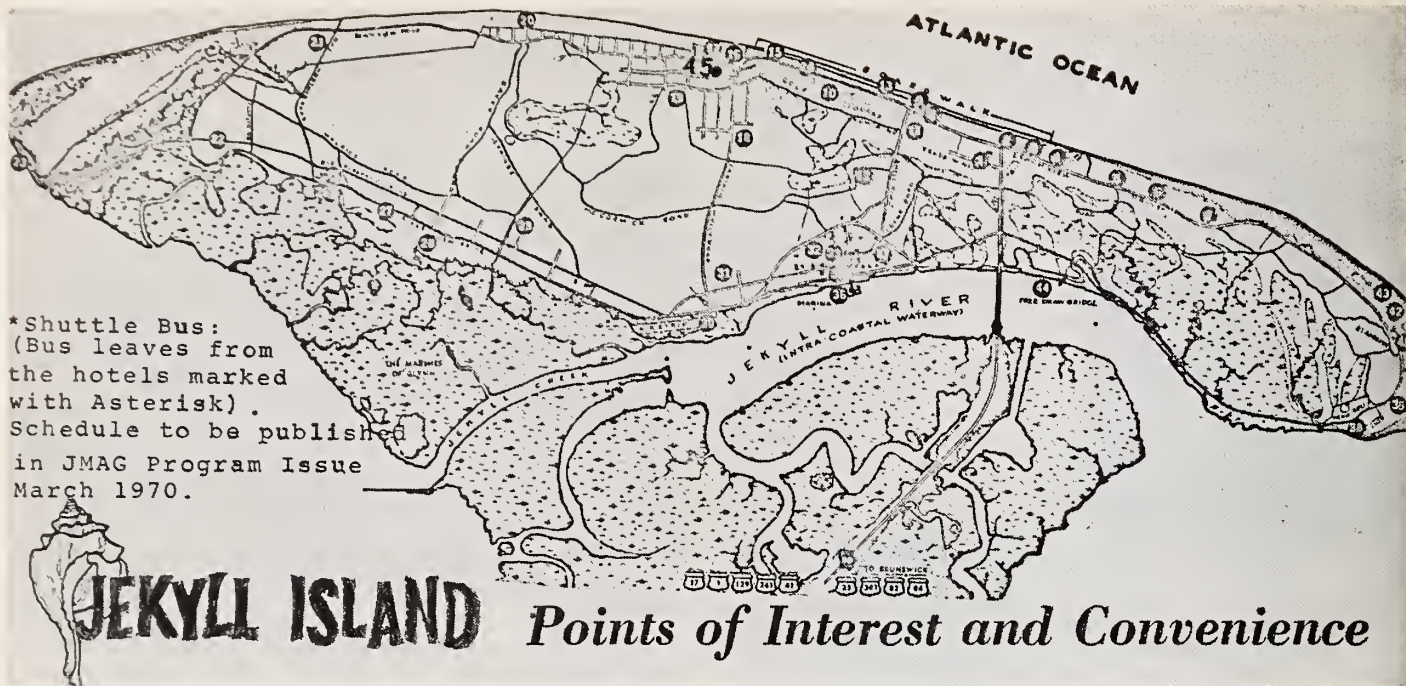
**Kenneth L.
Vaux, Th.D.**

On April 16-17, the Committee on Medicine, Religion and Law of the Cobb County Medical Society will present SYMPOSIUM '70, "Frontiers of the Mind," which will probably be the most exciting and provocative of all the programs during the five-year history of these annual symposia. The speakers will be Albert Rosenfeld, Senior Science and Medicine Editor of *Life* magazine, one of the country's leading science editors, the recipient of the two top awards in medical journalism (the American Association for the Advancement of Science's Westinghouse Award and the Lasker Award for leadership in medical journalism) and author of the recent book, *The Second Genesis—the Coming Control of Life*; Jose M. R. Delgado, M.D., distinguished neurophysiologist, internationally recognized pioneer in brain research, Yale University School of Medicine, whose investigations concerning implantation of electrodes in the brain of monkeys have demonstrated the possible control of human behavior and treatment of mental disorders, and author of numerous scientific articles and the book *Physical Control of the Mind: Toward a Psychocivilized Society*; James L. McGaugh, Ph.D., a specialist in learning and memory, Professor of Psychobiology and Dean of the School of Biological Sciences, University of California; Kenneth L. Vaux, Th.D., Associate Professor of Ethics in the Division of Interdisciplinary Research and Ethical Studies, The Institute of Religion, Texas Medical Center, Houston, Texas, and Associate Professor of Ethics in the Department of Psychiatry of Baylor Medical School, as well as Chaplain of Rice University and the Texas Medical Center; Dr. Allen E. Smith, Professor of Law, University of Texas; and an astronaut to be named at a later date.

SYMPOSIUM '70 will explore perspectives involved in this biomedical, biotechnological and cybernetic revolution that will have an overwhelming impact on the very fundamentals of religion, philosophy, law, medicine, morality, and the conduct of our daily lives. It will explore possibilities of manipulation of the mind, control of human behavior, problems involved in space exploration, and other aspects of this revolution which could possibly result in the future control of life.

All sessions will be held at Kennesaw Junior College, Marietta, Georgia, except for the Friday evening session with speaker Albert Rosenfeld, which will be held at the Royal Coach Motor Hotel in Atlanta. Co-sponsoring the symposium are the Cobb Judicial Circuit Bar Association, the Marietta-Smyrna Ministerial Association and Kennesaw Junior College.

Chairman of the Committee on Medicine, Religion and Law is Luther G. Fortson, M.D. and detailed information including registration blanks may be obtained by writing SYMPOSIUM '70, Department of Community Relations, Kennesaw Junior College, Marietta, Georgia 30060.



*Shuttle Bus:
(Bus leaves from
the hotels marked
with Asterisk).
Schedule to be published
in JMAG Program Issue
March 1970.

1. Shopping center, Authority office, post office, police.
- *2. Aquarama containing 2,500 seat convention hall with indoor heated pool.
3. South public bath house.
- *4. Corsair Motel and Restaurant.
- *5. Buccaneer Motel and Restaurant.
- *6. Carriage Inn Motel and Restaurant.
7. South picnic area.
8. Parking area.
9. Beach concession stand.
10. Ocean-side golf course.
11. Golf clubhouse and miniature golf course.
12. Eighteen-hole championship golf course.
13. Beach walk—1¾ miles fronting ocean.
14. North public bath house.
15. Beach concession stand.
- *16. Wanderer Motel and Restaurant.
- *17. Jekyll Estates Motel.
18. Oakgrove residential area.
19. Palmetto residential area.
20. Jekyll Beach residential area.
21. North picnic area.
22. Cherokee Campground.
23. Driftwood Beach.
24. Clam Creek fishing and picnic area.
25. Ruins of Major Horton's House.
26. Historical DuBignon Cemetery.
27. Ruins of Georgia's first brewery.
28. Picnic Area.
29. Plantation residential area.
30. Paved airstrip.
31. Pinegrove residential area.
32. Auditorium.
33. Faith Chapel.
34. All-weather tennis courts and clubhouse.
35. Jekyll Club Hotel and Village Area.
36. Jekyll Island Marina and boat docks.
37. Jekyll Island Museum.
38. Picnic Area.
39. St. Andrews residential area.
40. Miniature golf course.
41. Proposed Teen Center.
42. Beach casino and recreational area.
43. St. Andrews Auditorium.
44. Proposed yacht basin.
- *45. Seafarer.

THE ANNUAL SESSION—A MINI-SCHEDULE

Thursday, May 7, 1970

- 11:00 a.m.—Registration Opens, Aquarama
 11:30 a.m.—Auxiliary Pre-Convention Board Luncheon, Buccaneer
 1:30 p.m.—First General Session, Aquarama
 2:30 p.m.—Specialty Society Meetings (See March Program Issue)
 6:00 p.m.—Specialty Society Receptions and Dinners (See March Program Issue)

Friday, May 8, 1970

- 9:00 a.m.—Second General Session
 First Session of House of Delegates and Calhoun Lectureship, Aquarama
 9:30 a.m.—Auxiliary General Meeting, Buccaneer
 2:00 p.m.—General Meeting, Aquarama
 6:00 p.m.—Alumni Receptions and Dinners (See March Program Issue)

Saturday, May 9, 1970

- 9:00 a.m.—Reference Committee Meetings, Carriage Inn
 Auxiliary General Meeting, Buccaneer
 12:00 noon—Auxiliary Luncheon, Cloister
 2:00 p.m.—General Meeting, Aquarama
 6:30 p.m.—MAG Annual Reception and Banquet, Aquarama

Sunday, May 10, 1970

- 9:00 a.m.—Auxiliary Post Convention Board Breakfast, Buccaneer
 9:00 a.m.—Third General Session and Second Session of House of Delegates, Aquarama
 12:00 noon—Adjournment

Medical Association of Georgia Annual Session

May 7-10, 1970—Jekyll Island, Georgia

RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
(Motel of your choice)
Jekyll Island, Ga. 31520
2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible confirmation will be in accordance with preference indicated, if not, best substitute will be made.
4. Unreserved accommodations will be released on April 23, 1970.
5. A deposit in the amount of one night's lodging, plus 3% Georgia State sales tax, is required to assure your reservation. Make check payable to motel of your choice.
6. Rooms will not be ready for occupancy until 3:00 p.m. on day of arrival. Check-out time is 12:00 noon on your departure date.
7. A quick check out card will be placed in each room. Turn this in at Registration Desk and you will be billed later.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Name of Motel		Bedroom 1-2 persons	Kitchenette 1-2 persons	Each Additional Person
Buccaneer Motor Lodge	(Ocean)	\$17-20	\$20-24	\$1.00
	(Court)	\$16-18	\$18.00	\$1.00
Corsair Motel	(Ocean)	\$21.00	\$22.00	\$2.00
	(Drive)	\$18.00	\$19.00	\$2.00
Stuckey's Carriage Inn	(Pool)	\$21.00		\$2.00
	(Drive)	\$19.00		\$2.00
Wanderer Motel	(Ocean)	\$20.00	\$21-26	\$2.00
	(Drive)	\$17.00		\$2.00
Seafarer Motel	(Drive)	\$14.00	\$16.00	
Jekyll Estates Motel	(Ocean)	\$18.00		

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Cut out and send to motel of your choice:

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MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION

MAY 7-10, 1970

NAME

ADDRESS

CITY & STATE ZIP

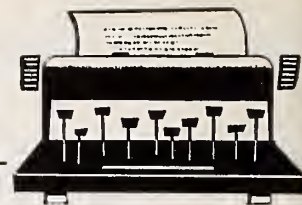
ARRIVAL DATE DEPARTURE DATE

I DESIRE ACCOMMODATIONS AT (1st) (2nd) MOTEL

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS

I DESIRE TRANSPORTATION FROM TO MOTEL

FLIGHT # TIME



Viral Valvulitis

CALCIFICATION OF VALVE CUSPS usually occurs when there is long standing chronic rheumatic endocarditis. Occasional calcification and consequent sclerosis of the aortic valve may occur as a "primary degenerative process." In the fully developed stage it is indistinguishable from the much more common calcific aortic stenosis of rheumatic origin.

Some instances of chronic valvular disease of the heart previously thought to be post rheumatic in origin may represent chronic viral valvulitis. Human viral valvulitis and endocarditis along with myocarditis may well be more common than previously suspected. It is now well known that many situations involving viral carditis may go unnoticed.

During the past few years a significant number of patients with Cocksackie viral myocarditis have been reported. Since the lesions are usually small, localized and widely separated, they may often be overlooked. With routine hematoxylin-eosin stains only scattered patchy interstitial cellular infiltration may be noted. Actually, previous reports indicate that a virus often can be isolated from tissues in which there is no histologic evidence of inflammation or infection. Because of these facts the true incidence may be considerably higher than suggested by the present literature.

With the advent of immunofluorescent techniques one may readily reveal the presence of viral antigens within affected cells. It is obviously much easier to identify a viral antigen by this method than to recover living viruses by means of in vitro cultivation of infected tissue.

Studies by Burch

The widespread prevalence of mild viral respiratory tract infections with potentially cardiotrophic viruses such as Cocksackie in children and young adults prompted Burch and associates to search for Cocksackie viral antigen in the valves and myocardium of young patients dying of a variety of causes and coming to routine autopsy at the Charity Hospital in New Orleans. Their findings were quite exciting in that out of 55 autopsies, 17 hearts were positive for Cocksackie B viral antigens within the myocardium. There were three cases of mitral valvulitis all Cocksackie B1, B4 and B5 respectively. One of these patients was three days old, another five years and a third 55 years. The latter had gross valvular thickening. Since these initial studies heart specimens from more than 1,000 human autopsies have been studied and have confirmed the presence of viral antigen in a significant proportion. Since the incidence of these infections is much higher in infants and young adults it seems likely that viral invasion at this time may produce a sub-clinical slowly progressive valvular damage.

Endocarditis has not been generally considered a complication of viral disease in man. However, clinicians are well aware that many patients with acute and chronic valvulitis have no history of rheumatic fever, bacterial endocarditis or syphilis. This group of patients in the past has been largely ignored. Burch and as-

sociates have been able to infect mice and monkeys with Cocksackie viruses and produce varying degrees of myocarditis, endocarditis and valvulitis in these animals similar to those seen in man.

Conditioning factors such as cardiac puncture before inoculation of virus intravenously may increase incidence of cardiac lesions in viral infected rabbits from 25 to 86 per cent. Intravenous gum acacia and small repeated doses of pitressin cause a significant increase in incidence and severity of myocarditis when the virus was subsequently introduced. These findings have been reported by Pearce. Such conditioning factors are probably of real significance in altering the incidence and severity of cardiac disease in man following infections of various sorts. The physical trauma of valve closure in the presence of hypertension, physical trauma and other stresses could function as conditioning factors which determine the development of viral valvulitis.

This is an area in which much more investigation needs to be carried out. If the findings of Burch and others can be confirmed and extended our understanding of chronic valvular disease will be considerably widened.

REFERENCE

Burch, G. E. and Colcolough, H. L.: Viral valvulitis; *Am. Heart J.* 78:1, pp. 119-123, July, 1969.

SOUTHEASTERN REGIONAL MEDICAL LIBRARY PROGRAM BEGINS SERVICES

As of January 1, 1970, the Southeastern Regional Medical Library Program inaugurated services to health professionals and institutions in the states of Alabama, Florida, Georgia, Mississippi, South Carolina, Tennessee, and the Commonwealth of Puerto Rico.

The 12 larger medical libraries in the region have formed a consortium to develop the program. Members are termed Resource Libraries and include the University of Alabama Medical Center Library, Birmingham; the University of Florida, J. Hillis Miller Health Center Library, Gainesville; the University of Miami School of Medicine Library, Miami, Fla.;

The University of South Florida School of Medicine Library, Tampa; the Emory University School of Medicine, A. W. Calhoun Medical Library, Atlanta; the Medical College of Georgia Library, Augusta; the University of Mississippi Medical Center, Rowland Medical Library, Jackson; the University of Puerto Rico Medical Sciences Campus Library, San Juan;

The Medical University of South Carolina Library, Charleston; the Meharry Medical College, Meharry Alumni Library, Nashville, Tenn.; the University of Tennessee Medical Units, Mooney Memorial Library, Memphis; and the Vanderbilt University School of Medicine Library, Nashville.

Administrative Headquarters

The A. W. Calhoun Medical Library, Emory University School of Medicine, is serving as administrative headquarters for the Southeastern Regional Medical Library Program. Mrs. Miriam H. Libbey, librarian of the A. W. Calhoun Medical Library, has been chosen by an advisory council to serve as chairman of a seven-member executive committee for the program.

The Medical Library Assistance Act of 1965 of the U.S. Congress paved the way for the Regional Medical Library Program which is designed to expand and improve medical library service and facilities for the health sciences community. It will coordinate programs in existing institutions, creating a nationwide biomedical communications network with the National Library of Medicine as center.

Some 11 regional medical libraries are being designated, including the Southeastern Regional Medical Library.

Supplementary Services

Distribution of regional services will be a cooperative endeavor, designed not to supplant but to supplement those services already being offered by member libraries.

These services are available (1) to public and private institutions with programs of health professional education, service, or research, and (2) to individuals engaged in these or related fields who lack access to libraries through which to obtain services.

Initial plans call for expanded interlibrary loan service, including free photocopies in lieu of original material. A union list of serials holdings for the consortium members will expedite this service.

Bibliographies can be formulated from computer search through the National Library of Medicine's Medical Literature Analysis and Retrieval System (MEDLARS).

Continuing education programs will feature a MEDLARS workshop for librarians. During the year similar instruction will be given user groups.

Through a newsletter and announcements, close communication will be maintained for all health science libraries in the region.



CORONARY ARTERY COLLATERAL CIRCULATION—MYTH OR MAJOR COMPENSATORY MECHANISM?

CHARLES A. GILBERT, M.D., *Atlanta*

IS THE HEART a rich synctium of interconnecting arterioles and capillaries that will allow circumvention of major coronary artery obstruction, or are the coronary arteries "end arteries"? This argument has occupied anatomists, physiologists, radiologists and clinicians for several hundred years and has potential significance for every practicing physician since coronary atherosclerotic heart disease (C.A.H.D.) is our nation's number one cause of death. Can collateral vessels adequately bypass significant coronary artery obstruction? Can drugs, exercise or ischemia stimulate the growth and development of coronary vessels?

Recently, information on these fundamental aspects of coronary collateral anatomy and physiology has excited attention. It is now abundantly clear that coronary collaterals exist in dog, pig and human hearts. Many reports, utilizing many different methods, have shown the existence of collaterals in the human ranging from 40 to 300 μ . These are demonstrable as early as the newborn and are present into the old age periods. The mere existence or demonstration of these thin-walled vessels, however, is not enough to infer function. It is known that a sudden occlusion of the anterior descending coronary artery in man, dog or pig will cause a myocardial infarction. Collateral vessels, unless otherwise stimulated, can only provide a small percentage of the blood supply needed to maintain myocardial muscle viability within 24-48 hours of a sudden complete occlusion of a previously normal vessel. Coronary atherosclerosis is a slowly progressive disease, though, and its encroachment on coronary vessel lumen, coronary blood flow and myocardial oxygen supply occurs over decades. Schlesinger and his colleagues have demonstrated in human pathology studies that coronary collaterals can successfully take over the job of supplying blood to the distal portion of occluded coronary arteries. In fact, in those studies over 95 per cent of hearts with complete occlusion of a major coronary artery were found to have a significant collateral bed supplying distal portions of the occluded arteries, although this did not always prevent infarction or areas of fibrosis. Similarly, more than half of the hearts with severe coronary narrowing had significant collateral formation. These results have been confirmed by the coronary angiographic studies of Sones, Judkins and others. Other pathologic situations associated with increased collateral formation are anemia, cardiac hypertrophy, valvular disease and cor pulmonale.

Recently, in myocardial infarction caused in dogs by acute ligation of the circumflex coronary artery, Rees and Redding have demonstrated a return to normal

levels of myocardial radioactive Xenon washout by 10 days after the infarction. Kong, Chen, et al. have angiographically demonstrated functioning collaterals in young pigs within two to four weeks following infarction. Schaper has shown a marked increase in cellular mitosis within small collateral vessels following occlusion of a major coronary vessel. The stimulus to growth of these vessels, Schaper has suggested, is an increase in tangential wall stress from the marked pressure differences following a major vessel occlusion. Whether the stimulus to collateral vessel growth is such a physical one, or as suggested by Schlesinger's studies is a chemical-metabolic one, has not been completely resolved.

Does jogging and physical endurance conditioning contribute to cardiovascular health by stimulating coronary collateral circulation? Eckstein produced moderate to severe single coronary artery narrowing in dogs by surgical ties. He was able to show that collaterals in exercised dogs produced more flow from the severed end of an artery distal to the narrowing, than occurred in rested dogs. It is also possible to show a heavier total coronary artery vascular bed by weighing vinylite casts from rats who have exercised two to three days a week compared to sedentary rats. These limited studies do not prove that endurance physical activity stimulates coronary collateral growth in humans. Further studies, both in experimental animals and man, will be necessary to evaluate the possible role of exercise.

At the present time there is no known drug which will influence coronary collateral growth.

In summary, while coronary collaterals are ubiquitous and myocardial collateral blood flow can occasionally prevent infarction in the presence of slowly progressive coronary narrowing, we need to know more about the stimuli to vessel growth.

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(2) Samuel N. Workman, M.D.
Chief of Clinical Services

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CALIFORNIA ANTI-TRUST SUITS AGAINST MALPRACTICE INSURERS

JOHN L. MOORE, JR., *Atlanta**

TWO COMPLAINTS HAVE BEEN FILED in California against several insurance brokers and insurance companies. One suit was filed in the United States District Court in San Francisco by Melvin M. Belli for himself as plaintiff and for the people of the State of California as a class. The other suit has been filed in the United States District Court in Los Angeles on behalf of five physicians representing among them the specialties of orthopedic surgery, general surgery, internal medicine, and anesthesiology. The two complaints are very similar but differ as to the class of plaintiffs represented.

Alleged Reasons for Complaint

It is alleged that the defendants, either as insurance brokers or as insurance companies, have decided among themselves that medical malpractice insurance risks should be "pooled" and divided up among the list of defendants. It is alleged that the different defendants have met and conspired together to "fix, stabilize and maintain uniform, arbitrary, non-competitive, excessive, and oppressively outrageous prices, terms, and conditions of sale" as to professional liability insurance to physicians and hospitals. Mr. Belli's complaint alleges that current premiums are 10 and 15 times higher than two years ago and in some cases, in excess of \$20,000 annually. Mr. Belli also alleges that, from the patient's point of view, approximately 15 to 20 per cent of every dollar paid by California patients for medical care and treatment from doctors and hospitals goes to the payment of premiums for malpractice insurance.

Mr. Belli also complains that the defendant insurers have exerted pressure and control upon doctors and hospitals "so as to coerce and restrain said doctors from testifying on behalf of the plaintiff in medical malpractice lawsuits, a situation commonly known as 'conspiracy of silence.'" Mr. Belli also alleges that the insurers have coerced doctors and hospitals to purchase all other necessary types and kinds of insurance coverage from them as a condition precedent to the issuance of professional liability insurance. Mr. Belli complains rather eloquently that a part of the conspiracy has been to advertise to the medical community and the general public of California that the reason for the increase in insurance premiums is due to recoveries by injured plaintiffs represented by Mr. Belli and other attorneys who regularly represent plaintiffs in medical malpractice cases. Mr. Belli argues that in fact the insurers are simply trying to make excessively profitable insurance arrangements.

The physicians' complaint speaks of the suppression of competition from those who might provide competitive medical malpractice insurance. Their complaint al-

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

so charges the defendants with the fixing of prices at exorbitant and outrageously high levels and the forcing of physicians to purchase all other necessary types of insurance coverage as a condition precedent to the issuance of medical malpractice insurance. The physicians also allege that the defendants have attempted to coerce any medical doctor from taking affirmative action to rectify and adjust "this predatory situation, by threatening cancellation of said doctor's medical malpractice insurance, or in the alternative the charging of even higher insurance premiums to said medical doctor."

Nature of the Plaintiffs

As stated above, Mr. Belli has filed his suit as a class action in the interest of all of the people of the State of California as a class as patients. He prays a recovery of \$200,000,000 as treble damages. His complaint asks the Court to establish a trust of the recovery to be used in the payment of claims of citizens and residents of the State of California who are injured and damaged as a result of professional negligence on the part of uninsured doctors or hospitals.

The physicians' complaint alleges that they are unable to state an amount of damages but that they will amend their complaint at a later time when they know what the proper amounts are. The physicians ask for a sufficient recovery as treble damages to compensate their class, which is the 12,000 physicians practicing in Los Angeles County. Presumably the amount of recovery would be determined by multiplying the excessive insurance premiums by three.

Comment

It is obvious that the final outcome of these lawsuits will be extremely important not only to the insurance companies in the United States but also to physicians and patients. If the plaintiffs in California are able to prove their allegations and effect anything like the recoveries requested, the effects will be extremely devastating on insurance companies writing malpractice insurance. If the allegations should prove to be true and the insurance companies are shown to be making excessively high profits, then some correction in premium structure might result.

Suite 1220
C & S Bank Building

Let no one who can be his own belong to another.
—Paracelsus

OSLER'S VIEWS ON MEDICAL EDUCATION

"Problems and patients suffice for the men in charge of the clinical side of Research Institutes, but only a very narrow view regards the Director of a University clinic as chiefly for research. He stands for other things of equal importance. In life, in work, in word and in deed he is an exemplar to the young men about him, students and assistants. Cabined, cribbed and confined within the four walls of a hospital, practising the fugitive and cloistered virtues of a clinical monk, how shall he, forsooth, train men for a race, the dust and heat of which he knows nothing and—this is a possibility—cares less? I cannot imagine anything more subversive to the highest ideal of a clinical school than to hand over young men who are to be our best practitioners to a group of teachers who are ex officio out of touch with the conditions under which these young men will live."

—Sir William Osler



SUTTON'S LAW

WILLIE SUTTON, erstwhile bank robber and escape artist, walked out of prison through the front door the other day. This in itself was no great accomplishment for Willie, but for The Establishment, as years ago Willie had boasted there was no bank he could not rob, and no prison from which he could not escape.

For a while, it seemed that this was no idle boast. Many were the banks that fell to Willie and many were the jails from which he escaped. Finally, the law and the law of averages caught up with him. He was sentenced to life imprisonment, from which he was parolled in December, 1969, after serving 35 years. During the height of his career Willie was asked why he robbed banks, and his answer was a straightforward one: "Because that's where the money is."

This direct answer was remembered a decade later by a Dr. William Dock, when he was called in consultation on a difficult case which he diagnosed by the direct approach. He therewith propounded "Sutton's Law" which, paraphrased, recommends that doctors assessing symptoms first use the test more likely to provide the diagnosis in each case, that they dispense with the series of routine examinations and thus avoid being side-tracked by "red herrings."

The multiple ways that such proceedings could save time and effort in diagnosis are obvious. It would be nice, however, if we could go back to basics and expand the law to cover some of the ever-increasing load of clerical work that goes along with the medical aspects of treating the patient today and to do away with some of the clerical "red herrings."

If Willie Sutton became ill today, his physician might *try* to approach the diagnosis and treatment of his illness with the same directness that Willie assumed about robbing banks—"Because that's where it's at." But, his physician could do this only after identifying Willie by a number with at least six digits, his address with zip code number, his telephone by his area code and a six digit number.

Then, of course, his disease would have to be identified by a code number and the same for his operation, if any, or his medical treatment. Separate code numbers would be required for the examination and treatment of each of Willie's several anatomical parts, and of course the final disposition of Willie's case would call for another identifying number multiplied by a conversion factor. All these numbers would be entered on a complicated form which would be mailed to the proper computer, which would then in all probability return it to the diagnosing, treating and numbering physician for another number.

Thirty-five years ago when Willie Sutton was running rampant and his approach to bank-robbing was so direct—"Because that's where the money is"—his approach to getting well was probably the same. He approached his physician for a

cure because "That's where the cure is." Though today Willie's physician might try to follow Sutton's law of direct approach in his diagnosis and treatment, the direct approach to Willie's illness without a cat's cradle of numerology is a thing of the past. *Sic transit* Sutton's law.

John Kirk Train

John Kirk Train, M.D.
President, Medical Association of Georgia

*It is a distinct art to talk medicine in the language of
the non-medical man.*

—Edward H. Goodman

AVEN RECEIVES AWARD



Carl Aven, M.D., of Marietta, first recipient of the MAG annual award for Civic Endeavor, receives plaque from John Atwater, M.D. The Civic Endeavor award is given for outstanding participation in civic and community activities. Presentation of the award for 1969 was made at the December meeting of the Fulton County Medical Society.

THE ASSOCIATION



NEW MEMBERS

Alpern, Robert J. DE-2—DeKalb—PD	1600 Clifton Road, N.E. Atlanta, Georgia 30322
Biggs, James R., Jr. Active—Muscogee—R	The Medical Center Columbus, Georgia 31902
Caras, Thomas S. Active—Cobb—I	792 Church Street Ext., N.E. Marietta, Georgia 30062
Ezzard, George P. Active—Chattahoochee— GP	Crogan Street Lawrenceville, Georgia 30245
Fleming, Sidney H. Active—DeKalb—P	1256 Briarcliff Rd., N.E. Atlanta, Georgia 30306
Flynn, Thomas F. Active—Stephens—Su	Medical Arts Clinic Toccoa, Georgia 30577
Fordham, Christopher C. Active—Richmond—I	Medical College of Georgia Augusta, Georgia 30902
Kistler, Henry E., Jr. Active—Stephens—OBG	304 N. Sage Street Toccoa, Georgia 30577
Prince, Russell B. Active—DeKalb—P	755 Columbia Dr. Decatur, Georgia 30030
Roberts, Sava M. Active—Sumter—R	Sumter County Hospital Americus, Georgia 31709
Whitaker, Cecil F. Active—Muscogee—OBG	629 20th Street Columbus, Georgia 31902

SOCIETIES

Fulton County Medical Society has elected Robert E. Wells as president-elect for the year 1971. F. William Dowda is their president for 1970. Other officers for this year are Hugh Thompson, vice president; Edwin C. Evans, senior board member; and Alton Hallum, Jr., junior board member.

The **Georgia Medical Society** featured Alan Guttmacher, M.D., president of the Planned Parenthood Federation of America, Inc., as guest speaker at their January meeting.

The **Habersham Medical Society** has elected James B. Wilbanks as their new president. He will serve with L. G. Hicks, vice president; F. O. Garrison, secretary-treasurer, and Tom Lumsden, delegate.

Hart Sylvester has been elected president of the **Ocmulgee Medical Society**. Also elected were Richard Smith, vice president, and W. E. Coleman, secretary-treasurer.

Richmond County Medical Society has installed Julius T. Johnson as president for 1970, Menard Ihnen, president-elect, Jack B. Lindley, vice president, and Kenneth McDonald, secretary-treasurer.

PERSONALS

First District

Franklyn P. Bousquet, Jr., has been elected president of the medical staff at Candler General Hospital for 1970.

Second District

R. E. Jennings and **Homer Lassiter** attended a special heart training course offered by Archbold Memorial Hospital in Thomasville with the support of the Georgia Regional Medical Program. The course was designed to help area hospitals staff monitored cardiac beds and coronary care units.

Tenth District

Loree Florence retired from practice on December 1 after more than 40 years of service. She was the first woman to enter and be graduated from the Medical College of Georgia.

The human body is a machine which winds its own springs: the living image of perpetual movement.

—Julien Offroy de La Mettrie

THE MONTH IN WASHINGTON

The Internal Revenue Service postponed until next Jan. 1 one provision of a new requirement that health insurance companies report to the IRS payments of \$600 or more a year to a physician.

The delayed provision covers payments other than under medicare and medicaid. Payments of \$600 or more under these government programs must be reported to the IRS. A spokesman said the reporting of payments other than under the government programs was delayed for a year to allow further time for working out compliance procedures.

The IRS regulation applies only to direct payments to physicians. The Senate added an amendment to an omnibus tax bill that would have extended the requirement to indirect payments also. But House-Senate conferees took out the amendment.

Another provision unfavorable to physicians was knocked out of the tax bill, but a third was retained.

The Senate rejected a proposal that would have restricted the tax advantages gained by physicians who organize professional corporations under state laws to establish retirement plans. The Senate Finance Committee had added an amendment that would have set an annual limit of \$2,500 per individual, the same as specified under the so-called Keogh law. But the Senate, by a vote of 65-25, knocked out the amendment, leaving physicians, lawyers, engineers and other mem-

bers of professional corporations able to set aside as much of their income for retirement as they choose.

As finally passed by Congress, the measure includes a provision putting congressional approval on an IRS ruling that advertising revenue of medical and other non-profit, tax-exempt organizations is subject to the regular corporate income tax. Journals of state medical societies, as well as the *Journal of the American Medical Association*, are affected.

Higher Premium

Medicare's Part B premium partially covering physicians' fees will go up from \$4 to \$5.30 a month next July 1.

Health, Education and Welfare Secretary Robert H. Finch blamed his predecessor in the post, Wilbur J. Cohen, for the size of the 32 per cent increase in the premium which is matched by the federal government.

Finch noted that the present \$4 premium rate, set in December 1968, was too low to cover costs during the current premium period and that the special Medical Insurance Trust Fund has been drawing on its reserves. He said that failure to increase the premium rate last December, in accordance with advice from Social Security Administration actuaries had made it necessary now, in effect, to promulgate two increases at once. Moreover, the depletion of the trust fund that



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals. The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients

and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction. Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy. We will be pleased to provide further information upon request.

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has occurred because of the inadequate rate had made it necessary, he said, to provide for a somewhat higher margin of contingency than would otherwise be necessary.

Distribution

About half the increase, 64 cents, was needed to finance the program at the level of current operations. The other 66 cents of the \$1.30 increase was distributed:

- 26 cents to cover an estimated increase of about 6 per cent in the level of physicians' fees;

- about 12 cents to cover an estimated increase of 2 per cent in the utilization of services under the program;

- about 6 cents because the \$50 deductible which a patient pays will be a smaller proportion of the total covered charges;

- the remaining 22 cents to provide a 4 per cent margin for contingencies.

Safety Standards

President Nixon signed into law legislation setting tough federal safety standards for coal mines.

Although he had reservations about a conflict with state workmen's compensation laws, Nixon said "the health and safety provisions of this act represent an historic advance in industrial practices." He also cautioned that this law should in no way "be considered a precedent for future federal administration of workmen's compensation programs."

The Secretary of Health, Education and Welfare was given for the first time authority to set health standards for mines. Nixon said he had asked that wherever possible the disability standards under the new act be consistent with those of the Social Security disability program.

Pressure for the legislation started building up after 78 died in a Mannington, W. Va., mine disaster last November.

AMA Support

The AMA supported an overall Administration bill on occupational health and safety, and pledged the backing of the nation's physicians for any program "well designed to improve the safety and health of the American worker."

Dr. R. Lomax Wells, Silver Spring, Md., immediate past chairman of the AMA's Council on Occupational Health, told a Senate labor subcommittee:

"... the American Medical Association supports the new Administration bill, S. 2788. Its provisions for standard setting, not in the Labor Department but in a new National Occupational Safety and Health Board appointed by the President, with a majority of professional experts, seems to us an acceptable equivalent to our previous suggestion of a National Council on Hazardous Physical and Chemical Agents. We endorse its concept of a separation of powers between stan-

dard setting and enforcement. We welcome, in this new bill, the intent to give a larger role to the Department of Health, Education and Welfare, whose competence in this field is recognized. Our Association approves the provision for federal support of state occupational safety and health programs to supplement inadequate manpower in the federal system. We believe that this emphasis on support of the state programs, combined with standard setting by an independent professional Board, is greatly preferable to mandatory national standards promulgated and enforced by a single federal agency. In this regard, we welcome the stress on the use of consensus standards, and provisions for consultation with professional standard-setting agencies before establishing needed new standards."

Heart Transplants

A National Heart and Lung Institute task force predicted that the demand for heart transplants will increase beyond the present level of about 100 a year and exceed the number of organs available for the operation.

The report of the task force on cardiac replacement also said:

- Less than 16 per cent of the 200,000 Americans under 65 who die each year from heart disease are good candidates for transplants.

- Rejection of the transplanted heart will remain "the greatest barrier to prolonged survival."

- Development of an artificial heart is now a distinct possibility.

- The federal government should emphasize research on the prevention, early detection and early treatment of heart disease.

- A new definition of death is needed.

- Total transplant charges for 36 patients averaged \$18,694 per patient.

- Heart transplants have been performed on 148 patients, with 23 persons still surviving, 16 of them in the United States.

- More than 32,000 heart disease victims can be considered transplant candidates, but there are only about 22,000 possible donors a year, the report said.

Reorganization

The Food and Drug Administration was reorganized and given independent status under a new commissioner.

The reorganization followed several years of criticism of the Health, Education and Welfare Department agency from all sides—Congress, industry and consumers' groups. The criticism resulted in a two-month study by a task force headed by HEW Deputy Assistant Secretary for Welfare Fred Malek.

The reorganization focused on FDA's structural problems and the chief aim of HEW Secretary Robert H. Finch appeared to be to get the agency operating more efficiently. FDA was taken out of the Consumer Protection and Environmental Health Service and placed in the department's staff structure on an equal basis with the remaining Environmental Health Service and the National Institutes of Health.

ATLANTA UNIVERSITY EXPLORES POSSIBILITY OF MEDICAL SCHOOL

*(Special report to faculty of Atlanta University from Dr. Thomas D. Jarrett, President,
December 10, 1969)*

A brief article about the findings of the Georgia State Health Department's Office of Comprehensive Health Planning appeared in the Atlanta newspapers last week. The article reported that many new physicians were needed in Georgia and that one or two new medical schools will be needed. Questions from many persons prompt this progress report.

Since November, 1968, at which time the trustees of Atlanta University discussed with Dr. Thomas D. Jarrett the possibility of a medical school on the Atlanta University Campus, considerable progress has been made toward initiating a feasibility study.

Outline of Progress

1. After conferring with officers at Emory University School of Medicine, Dr. Bernard Hallman, Associate Dean, was appointed to work with Dr. Jarrett and to furnish liaison between the two schools.

2. After reviewing the Regulations governing new medical schools, it seemed more logical to plan a feasibility study toward a four year school in the future as the University grows and develops. Meanwhile, the University would study the possibility of opening, as soon as possible, a two year medical school located on the Atlanta University Campus. This would require the cooperative efforts of Atlanta University, Emory University School of Medicine, and Grady Memorial Hospital. The Atlanta University graduates would transfer to Emory for their junior and senior years—taught largely at Grady Hospital. (Atlanta University graduates would not be required to transfer to Emory, but may transfer to any medical school of their choice.) They would receive the M.D. degree from Emory or some other four year school.

3. Dr. Jarrett has been assured that he has the backing of his faculty and the presidents of all of the member colleges. He has also reviewed the plans with the Atlanta Medical Society and received an affirmative vote.

4. Dr. Arthur Richardson, Dean of Emory University School of Medicine, is in favor of the development of a medical school at Atlanta University and has urged all of his faculty to cooperate as much as possible.

5. Dr. Bernard Hallman has discussed the project with the department chairmen of Emory University School of Medicine and with many faculty members—all have agreed to help in any way they can.

6. The consensus so far is that Atlanta University seems to be almost perfectly situated for a new two year (later, four year) medical school. It is an old, established, and growing university in a city with an established medical school and with a large public hospital.

7. On November 13, 1969, the subject was discussed again at the annual meeting of the Atlanta University Board of Trustees in New York. Dr. Jarrett was given permission to proceed with the feasibility study by a unanimous vote. This part of the study will deal with costs, building needs, possible sources of funds, and community support. This last study will require outside consultants and some financial support. One New York foundation has expressed interest in paying for the rest of the study.

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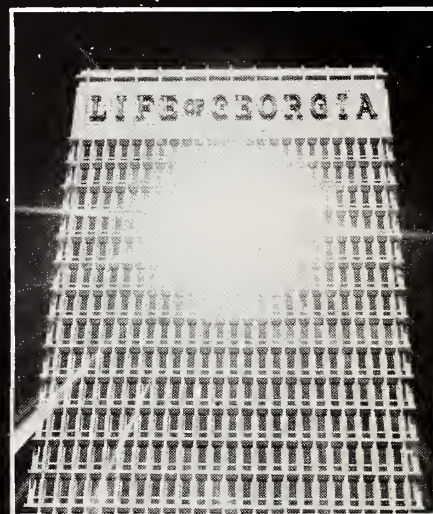
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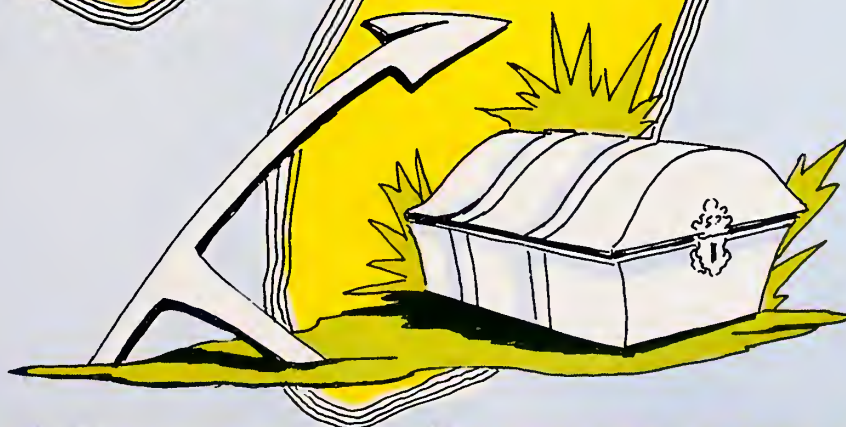
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Georgia

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Contents

1970 MAG Annual Session

OFFICIAL CALL	83
CALL FOR SCIENTIFIC EXHIBITS	85
OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA	86
OFFICIAL PROGRAM	88
SPECIALTY SOCIETY MEETINGS AND OTHER EVENTS	90
WOMAN'S AUXILIARY—THE PROGRAM AND OTHER DATA	93
MOTEL RESERVATIONS	101

Scientific Articles

USE OF COMPUTER IN THE STUDY OF RETINAL DISEASE AND RETINAL DETACHMENT William S. Hagler, M.D., William H. Jarrett, M.D., and George D. Presley, M.D.	102
A COOKBOOK OF ANTI-CANCER CHEMOTHERAPY FOR SOLID TUMORS Edgar D. Grady, M.D., Thomas R. Nolan, M.D., and A. J. Crumbley, M.D.	108
UNUSUAL REACTIONS TO COMMON CARDIOVASCULAR DRUGS Charles E. Harrison, Jr., M.D., and Nicholas E. Davies, M.D.	117

Special Articles

INSIDE MAG HEADQUARTERS Patricia A. Thigpen	105
MAJOR DIFFICULTIES IN SUCCESSFUL MENTAL HEALTH PROGRAM DEVELOPMENT ON COMMUNITY LEVEL Addison M. Duval, M.D.	121

Editorials

CEREBROVASCULAR DISEASE AND ORAL CONTRACEPTIVES	125
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Features

President's Letter	127
Calendar	99
Month in Washington	123

The Association

New Members	129
Societies	129
Personals	129
Deaths	129

Cover

Designed by Marie Seaman.

116th Annual Session Official Call

*Extended to All Officers and Members
of the Medical Association of Georgia*

WELCOME to the 116th Annual Session of the Medical Association of Georgia, at Jekyll Island, one of Georgia's Golden Isles.

General Sessions

The opening session will be called to order by John Kirk Train, M.D., Savannah, President of the Association, at 1:30 p.m., Thursday, May 7, in the Rotunda of the Aquarama. There will be the Presentation of Colors by the Naval Air Station Color Guard, and the National Anthem sung by Mrs. George W. Statham, Decatur, accompanied by the Brunswick High School Band. A welcome by the Glynn County Medical Society President and Chairman of the Jekyll Island Authority will be followed by a special program, the showing of a film entitled "This Is Frederica," made in the Spring of 1969 by the National Park Service, and starring well-known actors. The President-Elect's address will be a feature of this session.

The Second General Session on Friday, May 8, at 9:00 a.m., in the Rotunda of the Aquarama includes the Report of the Woman's Auxiliary and presentations by the two Student American Medical Association Presidents in Georgia.

The Third and Final General Session on Sunday, May 10, at 9:00 a.m. features a Religious Observance, the Memorial Service and presentation of the Certificates of Appreciation, the Life and Fifty Year Membership Certificates and Distinguished Service Award. The drawing of the name of the winner of the Commercial Exhibit Visitation Award also will be held. Immediately following the adjournment of the second session of the House of Delegates, the final session will reconvene for the installation of officers and adjournment of the 116th Annual Session.

General Meetings

Two General Meetings will be held in the Rotunda. On Friday, May 8, at 2:00 p.m., a session entitled "Government and Medicine" will be convened, and on Saturday, May 9 at 2:00 p.m., "Man, Moon and Medicine" will be presented.

Registration

A general registration desk for all participants will be open in the Aquarama from 11:00 a.m. to 5:00 p.m.

on Thursday, May 7; and 8:00 a.m. to 5:00 p.m., Friday and Saturday, May 8 and 9. On Sunday, May 10, the time will be 8:00 a.m. to 12:00 noon. Admissions to meetings and exhibits will be by registration badge only. There will be registration cards at the Specialty Society meetings for those who are attending. These cards will be turned in at the Official Registration Desk where badges, programs and banquet tickets may be obtained.

Council

The MAG Council will meet at 2:00 p.m., on Wednesday, May 6, in the Surrey Room of the Carriage Inn, and again immediately following adjournment of the Annual Session on May 10, in the Aquarama.

Reference Committees

All members are invited to appear before the Reference Committees of the House of Delegates on any business being considered by the House. Reference Committees will meet from 9:00 a.m. to 12:00 noon, Saturday, May 9, in assigned rooms at the Carriage Inn.

House of Delegates

The first session of the House of Delegates will convene on Friday, May 8, at 9:00 a.m., in the Rotunda of the Aquarama, immediately following the Second General Session, at which time nominations of MAG Officers will be made. The second meeting of the House will be convened on Sunday, May 10, in the same location at 9:00 a.m. The Reference Committee reports will be heard with resultant House actions and voting for MAG Officers will take place by ballot.

Calhoun Lectureship

The Abner W. Calhoun Lectureship speaker will be heard on Friday, May 8, in the Rotunda of the Aquarama immediately following the recess of the First Session of the House of Delegates.

Fifty Year and Life Members

Physicians to be awarded Life Membership, and those who have practiced medicine for 50 years will be honored at the Third General Session, Sunday, May 10, at 9:00 a.m., in the Aquarama Rotunda.

Life Members

James H. Byram	Atlanta
Cecil N. Brannen	Moultrie
V. L. Bryant	Wadley
T. J. Busey	Fayetteville
William M. Cason	Atlanta
Leila D. Denmark	Atlanta
Laurence B. Dunn	Savannah
John L. Elliott	Savannah
F. D. Funderburg	Monticello
J. D. Gray	Augusta
Zach W. Jackson	Atlanta
Ellen F. Kiser	Atlanta
William H. Kiser, Jr.	Atlanta
Harry N. Kraft	Atlanta
W. V. Long	Savannah
Joseph C. Massee	Atlanta
H. G. Mealing	Augusta
Jack C. Norris	Atlanta
Irvine Phinizy	Augusta
Vernon E. Powell	Atlanta
Calvin Sandison	Atlanta
William A. Smith	Atlanta
Trammell Starr	Dalton
Bruce Threatt	Columbus
Ebert Van Buren	Atlanta
William C. Warren, Jr.	Atlanta
J. N. Willis	Columbus
Richard Wilson	Atlanta
Charles Zimmerman	Tifton

50 Year Members

Henry D. Allen, M.D.	Milledgeville
Joseph D. Applewhite, M.D.	Macon
Charles S. Britt, M.D.	Brunswick
James J. Clark, M.D.*	Atlanta
Tom F. Davenport, M.D.	Atlanta
Milton T. Edgerton, M.D.	Atlanta
Earl H. Floyd, M.D.	Atlanta
J. Dewey Gray, M.D.	Augusta
John T. King, M.D.	Thomasville
Joseph H. Kite, M.D.	Atlanta
John C. O'Neill, M.D.*	Savannah
H. G. Weaver, M.D.	Macon

* Deceased.

Memorial Service

The Association will hold its traditional annual Memorial Service at the Third General Session on Sunday morning, May 10, 9:00 a.m., in the Aquarama Rotunda. The event will honor and recall the service and contributions of those deceased members in the past year.

Deceased Members

H. M. S. Adams, Atlanta, November 21, 1969
 Frank A. Blalock, Rome, July 8, 1969
 Cecil D. Cason, Waycross, February 6, 1970
 O. H. Cheek, Dublin, March 25, 1969
 James J. Clark, Atlanta, August 15, 1969
 H. E. Crow, Oakwood, October 30, 1969
 Charles L. Davis, Atlanta, June 7, 1969
 Guy J. Dillard, Columbus, June 4, 1969
 W. S. Dorrough, Atlanta, October 25, 1969
 Mark S. Dougherty, Jr., Grand Island, Florida, May, 1969
 I. A. Ferguson, Atlanta, February 26, 1970
 Joseph E. Griffith, Marietta, April 3, 1969
 O. S. Gross, Vidalia, March 1, 1969
 W. W. Hillis, Jr., Millen, November 30, 1969
 A. Robert Hornick, Augusta, March 17, 1969
 Frank F. Kanthak, Atlanta, December 5, 1969
 Max Mass, Macon, no date
 L. G. Neal, Cleveland, August 1, 1969
 W. Perrin Nicholson, Atlanta, July 12, 1969
 J. W. Palmer, Ailey, November 30, 1969
 W. E. Ragan, Jr., Atlanta, December 17, 1968
 George P. Sassos, Mt. Vernon, February 4, 1970
 Stacy H. Story, Jr., Valdosta, August 19, 1969
 William H. Tailer, Darien, January 18, 1970
 John E. Walker, Columbus, June 7, 1969

MAG Message Center

A message center will be maintained near the MAG Official Registration Desk for the convenience of the membership. Messengers from the Woman's Auxiliary will staff this center during the entire session for incoming messages only. A bulletin board at this message center will be available for notices of special importance during the Annual Session.

MAG Headquarters Office and Press Room

The Association Headquarters Office Staff will maintain a Headquarters Office in the Carriage Inn, Room 236, and one in the Aquarama for the conduct of Association business during the meeting.

A MAG Press Room will also be available in the Aquarama for newspaper, radio and TV personnel.

Hotel Reservations

Officers, Councilors, special out-of-state guest speakers and Delegates to the MAG House of Delegates will be housed in a reserved block of rooms and special reservation forms will be issued to the above by the MAG Office. All other members will be housed on a first come-first served basis by requesting desired accommodations direct to the motel of choice, on the form published in the *Journal MAG* for this purpose.

Elections

The nominations of Officers of the Association, AMA Delegates and Alternates, as well as the election of the General Practitioner of the Year, will be the order of business in the First Session of the House of Delegates on Friday, May 8. The delegates, at the Second Session of the House, on Sunday, May 10, will elect the Officers, AMA Delegates and Alternates, with installation at the final General Session immediately following the adjournment of the House. The Delegates Handbook will list the position vacancies and the method of election, as this will be the initial election of officers by the House.

Specialty Society Meetings and Social Events

The specialty societies have planned meetings, luncheons and dinners for the membership of their organizations, to be held in conjunction with the Annual Session. These events are listed in the Official Program under "Specialty Society Meetings and Social Events" with the date and time of the event.

Glynn County Medical Society Social Hour

The host society invites the membership and their wives to be their guests for cocktails on Saturday evening, May 9, from 6:30 to 7:30 p.m., preceding the Annual Banquet. The affair will be held in the Aquarama Patio or Room B, depending on the weather.

Annual Banquet

The Association will honor its President at the traditional Annual Banquet to be held Saturday evening at 8:00 p.m., May 9, immediately following the Glynn County Medical Society Social Hour, in the Aquarama Rotunda. The banquet will be in the form of a luncheon and informal sports attire would be appropriate. Entertainment will be furnished by a Polynesian musical group. The Hardman and Civic Endeavor Awards will

be made at the banquet and the incoming President will be inaugurated. Scientific Exhibit and Special Activities Awards will also be presented at this time.

Alumni Events

The Alumni Receptions and Dinners of the two Georgia medical schools, as well as other medical alumni, will be held on Friday evening, May 8. These are listed in the Program under the heading of Alumni Events.

Athletic Events

Golf, swimming and tennis tournaments are planned by the Glynn County Local Arrangements Committee, with J. L. Hunt, M.D., and Don R. Roberts, M.D., both of Brunswick, as Chairmen. The Medical Mile will be run on the beach starting from the Aquarama on Friday, May 8, at 5:00 p.m. Those interested should register at the Official Registration Desk.

Other Events

An Art Show will be on display in the Aquarama with exhibits of members' talents in the fields of sculpture, painting and photography. Prizes will be given for the first, second, third and honorable mention places in the show. Mrs. Marvin Engel, Brunswick, is in charge this year and you may contact her if you have an entry.

The Georgia Medical Political Action Committee will hold a breakfast for the Board of Directors at the Corsair on Friday, May 8.

Scientific Exhibits

Scientific Exhibits will be displayed in the Aquarama adjacent to the Commercial Exhibits. These are prepared by physicians who will be present to discuss their presentation with the membership. Awards for outstanding exhibits will be presented at the Annual Banquet.

Commercial Exhibits

Approximately 50 Commercial Exhibits will be displayed in the Aquarama. The exhibit hall will be used to gain both entrance and exit to the Rotunda Main Meeting Room. These exhibits will provide technical information and products and services available to the

profession. It is important that every member visit each of these exhibits and register with the exhibitor. The commercial exhibitors play an extremely important role in making the Annual Session possible through their support of the meeting.

Commercial Exhibitors

<i>Booth No.</i>	<i>Name of Firm</i>
1	Stansell's Oxygen Service, Inc., Atlanta, Georgia
2	Physicians Service, Inc., Columbus, Georgia
4	Marks Surgical Supply Inc., Augusta, Georgia
6	Wachtel's Physician Supply, Savannah, Georgia
9	OTC Professional Appliances, Atlanta
10	G. D. Searle & Co., Chicago, Illinois
11	Sandoz Pharmaceuticals, Hanover, New Jersey
12	Bristol Laboratories, Syracuse, New York
13	The Emko Company, St. Louis, Missouri
14	Astra Pharmaceutical Products, Inc., Worcester, Massachusetts
15	Office Communications, Inc., Atlanta, Georgia
20	Marshall Erdman Assoc., Inc., Princeton, New Jersey
23	W. B. Saunders Co., Philadelphia, Pennsylvania
24	Smith, Miller & Patch, Inc., New York, New York
25	CIBA, Summit, New Jersey
26	Mallinckrodt Pharmaceuticals, St. Louis, Missouri
28	Pfizer Laboratories, New York, New York
29	Ayerst Laboratories, New York, New York
31	Marion Laboratories, Inc., Kansas City, Missouri
32	Mead Johnson Laboratories, Evansville, Indiana
33	Wm. P. Poythress & Co., Inc., Richmond, Virginia
34	A. H. Robins Company, Richmond, Virginia
36	Merck Sharp & Dohme, West Point, Pennsylvania
37	Stuart Division, Atlas Chemical Industries, Inc., Pasadena, California
38	Warren-Teed Pharmaceuticals, Inc., Columbus, Ohio
39	Citizens and Southern National Bank, Atlanta, Georgia
41	Ortho Pharmaceutical Corp., Raritan, New Jersey
42	The Coca-Cola Company, Atlanta, Georgia
43	Parke-Davis & Company, Detroit, Michigan
44	Schering Laboratories, Union, New Jersey
45	Warner-Chilcott Laboratories, Morris Plains, New Jersey
46	S. J. Tutag & Co., Detroit, Michigan
47	First Southeastern Company and Natural Resources and Fund Inc., Denver, Colorado
48	
50	Imperial Fashion, Los Angeles, California

Commercial Contributions

Eli Lilly & Company, Indianapolis, Indiana
 Roche Laboratories, Nutley, New Jersey
 Smith Kline & French Laboratories, Philadelphia, Pennsylvania

CALL FOR SCIENTIFIC EXHIBITS

116TH ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

Jekyll Island, Georgia, May 7-10, 1970

For Information and Applications, Write:

John McClure, Jr., M.D., Chairman, MAG Scientific Exhibits Committee

938 Peachtree Street, N.E. • Atlanta, Georgia 30309



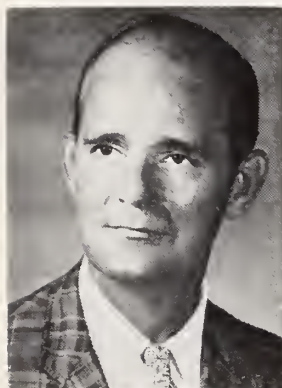
John Kirk Train
President



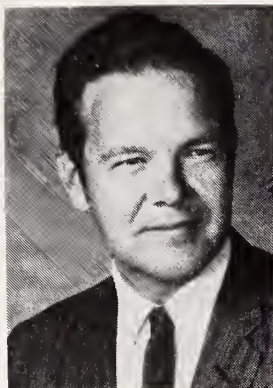
F. G. Eldridge
President-Elect



Ronald F. Galloway
First Vice President



F. W. Dowda
Second Vice President



John Rhodes Haverty
Secretary



C. E. Bohler
Chairman of Council

OFFICERS AND COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

OFFICERS

President—John Kirk Train, Savannah (1970) *
President-Elect—F. G. Eldridge, Valdosta (1970) *
Immediate Past President—Charles R. Andrews, Jr., Canton (1972) *
Past President—John T. Mauldin, Atlanta (1971)
Past President—Walter E. Brown, Savannah (1970)
First Vice President—Ronald F. Galloway, Augusta (1970) *
Second Vice President—F. W. Dowda, Atlanta (1970) *
Chairman of Council—C. E. Bohler, Brooklet (1970) *
Secretary—J. Rhodes Haverty, Atlanta (1972) *
Treasurer—John S. Atwater, Atlanta (1970) *
Speaker of the House—Harrison L. Rogers, Atlanta (1971) *
Vice Speaker of the House—Preston D. Ellington, Augusta (1971)
Editor, JMAG—Edgar Woody, Jr., Atlanta (1970)

COUNCILORS

District:

- 1—C. E. Bohler, Brooklet (1970)
- 2—J. D. Bateman, Albany (1970)
- 3—J. T. Christmas, Vienna (1970)
- 6—Ernest E. Proctor, Newnan (1971)
- 7—David A. Wells, Dalton (1971)
- 8—Robert E. Perry, Jr., Brunswick (1971)
- 9—P. T. Scoggins, Commerce (1972)
- 10—Edwin W. Allen, Jr., Milledgeville (1972)

Bibb County Medical Society
 Braswell E. Collins, Macon (1972) *
 Cobb County Medical Society
 W. C. Mitchell, Smyrna (1972)
 DeKalb County Medical Society
 Floyd R. Sanders, Decatur (1972)
 Fulton County Medical Society
 Fleming L. Jolley, Atlanta (1972)
 John T. Godwin, Atlanta (1971)
 J. Harold Harrison, Atlanta (1970)
 Georgia Medical Society
 Lee Howard, Jr., Savannah (1970)
 Muscogee County Medical Society
 Roy L. Gibson, Columbus (1971)
 Richmond County Medical Society
 J. L. Mulherin, Augusta (1972)

* *Executive Committee*

VICE COUNCILORS

District:

- 1—L. H. Griffin, Claxton (1970)
- 2—Donald J. McKenzie, Thomasville (1970)
- 3—John H. Robinson, Americus (1970)
- 6—Norman P. Gardner, Thomaston (1971)
- 7—Don Schmidt, Cedartown (1971)
- 8—Joe C. Stubbs, Valdosta (1971)
- 9—Robert S. Tether, Gainesville (1972)
- 10—M. A. Hubert, Athens (1972)

Bibb County Medical Society
 Milton I. Johnson, Macon (1972)
 Cobb County Medical Society
 Remer Y. Clark, Jr., Marietta (1972)
 DeKalb County Medical Society
 M. Freeman Simmons, Decatur (1972)
 Fulton County Medical Society
 T. J. Anderson, Jr., Atlanta (1972)
 J. Norman Berry, Sandy Springs (1971)
 W. W. Moore, Jr., Atlanta (1970)
 Georgia Medical Society
 W. W. Osborne, Savannah (1970)
 Muscogee County Medical Society
 Louis A. Hazouri, Columbus (1971)

Richmond County Medical Society
 Ronald F. Galloway, Augusta (1972)

DELEGATES TO AMA AS OF JANUARY 1, 1970

<i>Delegate</i>	<i>Term Ending</i>
J. W. Chambers, LaGrange	(12-31-71)
John S. Atwater, Atlanta	(12-31-71)
J. Frank Walker, Atlanta	(12-31-70)
P. D. Ellington, Augusta	(12-31-70)
<i>Alternate</i>	<i>Term Ending</i>
Neal F. Yeomans, Waycross	(12-31-71)
H. S. Jennings, Gainesville	(12-31-71)
J. D. Bateman, Albany	(12-31-70)
F. W. Dowda, Atlanta	(12-31-70)

CRITERIA FOR SELECTION OF RECIPIENTS OF MAG AWARDS

GENERAL PRACTITIONER OF THE YEAR—

This award is presented to an outstanding General Practitioner in Georgia. Selection of the recipient will be made by the House of Delegates from ballots cast during the first session of the House. The Georgia Academy of General Practice and component county medical societies are invited to make one or more nominations for this award. No nomination will be considered unless accompanied by supporting biographical data and received at the headquarters office of the Medical Association of Georgia at least two weeks prior to the opening of the Annual Session. No nominations for this award may be made from the floor of the House. The president of the Georgia Academy of General Practice will present this award at the first session of the House.

HARDMAN AWARD—This award is presented for "the achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery," or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor of the House. If given, this award will be presented at the Annual Banquet. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter from the late Governor Hardman establishing this award.

DISTINGUISHED SERVICE AWARD—The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical

societies and must be received by the headquarters office of the Medical Association of Georgia no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. If no nominations and supporting data are received, no award will be given. The recipient will be selected by a five-man secret committee and presentation will be made at the final general session of the Annual Meeting.

CIVIC ENDEAVOR AWARD—This is a new award available for presentation for the first time at the 1969 Annual Session and will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award, supported by appropriate data which must be received at the headquarters office of the Medical Association of Georgia at least two weeks in advance of the Annual Session. If no nominations and supporting data are received, no award will be given. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at the Annual Banquet.

CERTIFICATES OF APPRECIATION—The Committee on Awards will make recommendations to Council as to whom Certificates of Appreciation should be given. The Council of the Medical Association of Georgia retains the prerogative to add such names to this list as they deem wise. The Committee on Awards did not favor the automatic giving of Certificates of Appreciation to retiring committee chairmen unless, in the opinion of the committee or Council, such chairmen have performed good and deserving work. The committee points out consideration for these Certificates of Appreciation might well be extended to non-medical groups or corporations who have made outstanding contributions to medicine. These certificates are presented at the final general session.

OFFICIAL PROGRAM

THURSDAY, MAY 7

- 11:00 General and Delegates Registration**
Aquarama Entrance
- 12:00 Visit Exhibits**
- 1:30 First General Session**
(All MAG, Auxiliary Members and Guests Invited)
Rotunda, Aquarama
Presiding
John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Call to Order
Invocation
Dr. Charles W. Shedd, Minister, Presbyterian Community Church, Jekyll Island
Presentation of Colors
U.S. Naval Air Station Color Guard, Glynco
National Anthem
Soloist: Mrs. George W. Statham, Decatur
Band: Brunswick High School
Welcome
J. L. Owens, M.D., President, Brunswick, Glynn County Medical Society
Greetings
Mr. Horace Caldwell, Chairman, Brunswick, Jekyll Island Authority
Introduction of Distinguished Guests
Special Program: "This Is Frederica"
(National Park Service film)
President-Elect's Address
F. G. Eldridge, M.D., Valdosta, President-Elect, Medical Association of Georgia
Recess
- 2:30 Visit Exhibits**

FRIDAY, MAY 8

- 8:00 Registration**
Aquarama Entrance
- 8:30 Visit Exhibits**
- 9:00 Second General Session**
(All MAG Auxiliary Members and Guests Invited)
Rotunda, Aquarama
Presiding
John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Call to Order
Invocation
Reverend Talbert Morgan, Rector, St. Marks Episcopal Church, Brunswick
Report of the Woman's Auxiliary
Mrs. Charles R. Smith, Columbus, President-Elect

Report from the Student American Medical Association Chapter President
Mr. John R. Cone, President, Emory University School of Medicine SAMA Chapter

Mr. Ron F. Digby, President, Medical College of Georgia SAMA Chapter

Announcements
Recess

First Session, House of Delegates
Harrison L. Rogers, M.D., Atlanta
Speaker

Nominations of Officers, AMA Delegates and Alternates
Election of GP of the Year and Award Presentation

Introduction of Business
Recess

Abner W. Calhoun Lectureship
Presiding

John Kirk Train, M.D., Savannah, President, Medical Association of Georgia

The Future of Medicine
Carroll L. Witten, M.D., Louisville, Kentucky

12:30 View Exhibits

2:00 General Meeting
(All Physicians Invited)
Rotunda, Aquarama
Moderator
J. Frank Walker, M.D., Atlanta
Government and Medicine
(Panelists to be announced)

3:30 View Exhibits

5:00 The Medical Mile—MAG Athletic Event
Starting Line, *Beach Area, Aquarama*
Carson B. Burgsteiner, M.D., Savannah
Chairman

SATURDAY, MAY 9

- 8:00 Registration**
Aquarama Entrance
- 8:30 View Exhibits**
- 9:00 Reference Committee Meetings**
Carriage Inn
Reference Committee A:
Coach Room A
Reference Committee B:
Coach Room B
Reference Committee C:
Lounge
Reference Committee D:
Surrey Room A
Reference Committee E:
Surrey Room B

- 2:00 General Meeting**
(All Physicians Invited)
Aquarama Rotunda
Moderator
Ronald F. Galloway, M.D., Augusta
Man, Moon and Medicine
(Panelists to be announced)
- 3:30 View Exhibits**
- 6:30 Glynn County Medical Society Social Hour**
(All MAG Members, Their Wives and Exhibitors Invited)
Patio, Aquarama
- 8:00 Annual Banquet**
Aquarama Rotunda
Presiding
John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Presentation of Awards:
Special Activities Awards: Golf, Tennis, Swimming, Art Show and Medical Mile
Scientific Exhibit Awards
Hardman Award
Civic Endeavor Award
Inauguration of President of Medical Association of Georgia
Entertainment

SUNDAY, MAY 10

- 8:00 Registration**
Aquarama Entrance
- 8:30 View Exhibits**
- 9:00 Third General Session**
(All MAG and Auxiliary Members and Guests Invited)
Rotunda, Aquarama
Presiding
John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Call to Order
Religious Observance
Reverend Paul B. McCleave, Chicago, Illinois
Memorial Service
Reverend Paul B. McCleave, Chicago, Illinois
Presentation of Certificates of Appreciation
John Rhodes Haverty, M.D., Atlanta, Secretary, Medical Association of Georgia
Presentation of Life Membership Certificates
F. W. Dowda, M.D., Atlanta, Second Vice President, Medical Association of Georgia
Presentation of 50 Year Membership Certificates
Ronald F. Galloway, M.D., Augusta, First Vice President, Medical Association of Georgia

Presentation of Distinguished Service Award

John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Selection of Site for May 1974, 1975 and 1976 Annual Sessions
Recess

Second Session, House of Delegates Presiding

Harrison L. Rogers, M.D., Atlanta, Speaker
Election of MAG Officers, AMA Delegates and Alternates
Reference Committee Reports
Announcements
Adjournment

Third General Session (Reconvened)

Presiding
John Kirk Train, M.D., Savannah, President, Medical Association of Georgia
Installation of Officers
Announcements
Commercial Exhibit Visitation Drawing
Adjournment of 116th Annual Session

MEDICAL ASSOCIATION OF GEORGIA SECOND ANNUAL ART SHOW

All members of the Medical Association of Georgia and members of their immediate family are eligible to exhibit.

Artists may submit entries in one or more of the following categories:

1. Painting (Oil, acrylic, pastel and mixed media)
2. Water Color
3. Photography
4. Sculpture
5. Hobbies and Crafts

A member may enter two pieces in each class but not more than six in the show.

Medical pieces designed to illustrate anatomical or pathological conditions will not be considered eligible entries.

All paintings must be framed and ready to hang.

All photographs, except transparencies, must be matted. Exhibitors of transparencies must provide their own light source.

All pieces shipped by Railway Express or Air Freight must reach the Art Show Committee no later than May 6. All pieces delivered personally by the artist should be taken to the Aquarama on Jekyll no later than noon on May 7, the opening day of the Annual Session. All entries must remain until adjournment of the Session.

Children of physicians are urged to submit entries and will be judged separately.

For further information and details contact: Mrs. Marvin F. Engel, 728 Oglethorpe Avenue, St. Simons Island, Georgia 31522.

SPECIALTY SOCIETY MEETINGS AND SOCIAL EVENTS

(Not a Part of Official Program)

GEORGIA PEDIATRIC SOCIETY

Thursday, May 7

- 11:30 Social Hour, Luncheon and Business Meeting
Sky Room, Wanderer Motel
(Social Hour courtesy of Ross Laboratories)

GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

Thursday, May 7

- 6:00 Social Hour
Sky Room, Wanderer Motel
(Courtesy of Ross Laboratories)

Friday, May 8

- 9:00 Business Meeting
Sky Room, Wanderer Motel
- 12:30 Luncheon
Sky Room, Wanderer Motel
(Social Hour courtesy of Mead Johnson)

- 2:00 Scientific Meeting
Sky Room, Wanderer Motel
Dr. Angelo M. DeGeorge, Philadelphia, will speak on "Old Syndromes Renewed"; Dr. Charlton Mabry, Lexington, on "New Syndromes Reviewed," with a Kodachrome Clinic to follow

GEORGIA SOCIETY OF DERMATOLOGISTS

Saturday, May 9

- 8:30 Scientific Meeting
Sky Room, Wanderer Motel
Dr. Herbert Christianson, Tulane University, and Dr. Karl William Kitzmiller, University of Cincinnati, will discuss the development and use of the Laser beam.

- 12:00 Luncheon
Sky Room, Wanderer Motel

Sunday, May 10

- 10:00 Business Meeting
Sky Room, Wanderer Motel
- 12:00 Luncheon
Sky Room, Wanderer Motel

GEORGIA STATE OB-GYN SOCIETY AND GEORGIA CHAPTER, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

Thursday, May 7

- 3:00 Scientific Meeting
Mallard Room, Wanderer Motel
Dr. Stewart Fish, Memphis, will discuss "Gynecologic Endocrine Therapy in the Reproductive Years"; Dr. Roy Parker, Durham, "Trophoblastic Disease—Problems in Diagnosis and Management"; Dr. John J. Witte, Atlanta, "Current Concepts—Rubella."

- 5:00 Business Meeting (Public Health Physicians)
Mallard Room, Wanderer Motel

- 7:00 Social Hour and Dinner
Banquet Room, Wanderer Motel

GEORGIA SOCIETY OF OPHTHALMOLOGY

Saturday, May 9

- 8:30 Scientific Meeting
Mallard Room, Wanderer Motel

Sunday, May 10

- 8:30 Scientific Meeting
Mallard Room, Wanderer Motel

GEORGIA SOCIETY OF OTOLARYNGOLOGY

Saturday, May 9

- 9:00 Scientific Meeting
Room 400, Wanderer Motel

GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLGY

Saturday, May 9

- 1:00 Luncheon and Business Meeting
Banquet Room, Wanderer Motel

GEORGIA RADIOLOGICAL SOCIETY

Friday, May 8

- 6:30 Social Hour and Dinner
Cloister, Sea Island

Saturday, May 9

- 10:00 Business Meeting
King and Prince Hotel, St. Simons
- 2:00 Scientific Meeting
King and Prince Hotel, St. Simons

GEORGIA ORTHOPEDIC SOCIETY

Thursday, May 7

3:00 Scientific Meeting

Conference Room, Corsair Motel

Dr. Thomas Whitesides, Atlanta, will speak on "Spinal Injuries"; Dr. Wood Lovell, Atlanta, on "Spinal Deformities in Children"; Dr. Floyd Bliven, Augusta, on a subject to be announced later; Dr. James Becton and Dr. Joe D. Christian, Jr., Augusta, on "Foreign Bodies in the Hand in Children."

6:00 Social Hour and Dinner

Captain's Deck, Corsair Motel

GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Saturday, May 9

10:00 Business Meeting

Captain's Deck, Corsair Motel

12:00 Luncheon

Captain's Deck, Corsair Motel

(See Georgia Thoracic Society for joint meetings)

GEORGIA ACADEMY OF GENERAL PRACTICE

Thursday, May 7

11:30 Business Meeting and Luncheon

Pirates Cove, Buccaneer Motel

GEORGIA NEUROSURGICAL SOCIETY

Thursday, May 7

11:30 Business Meeting and Luncheon

Red Room, Buccaneer Motel

3:00 Business and Scientific Meeting

Red Room, Buccaneer Motel

GEORGIA DIABETES ASSOCIATION

Friday, May 8

7:30 Breakfast and Business Meeting

Red Room, Buccaneer Motel

GEORGIA THORACIC SOCIETY, GEORGIA TUBERCULOSIS ASSOCIATION AND GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Thursday, May 7

9:00 Scientific Meeting

Coach Room, Carriage Inn

Dr. Ronald F. Galloway, Augusta, will speak on "Preoperative Surgical Evalu-

ation of COPD"; Dr. John B. Bobear, New Orleans, on "Application of Pulmonary Function and Blood Gas Studies in Preoperative Patients with COPD"; and Dr. John Jarrell, Atlanta, on "Preoperative Anesthesia Evaluation in COPD"; concluding the morning session with Dr. David M. Little, Hartford, speaking on "Intraoperative Management of Patients with COPD."

11:30 Luncheon and Business Meeting

Coach Room, Carriage Inn

(Anesthesiologists have separate luncheon)

2:00 Scientific Meeting

Coach Room, Carriage Inn

Dr. Bobear will speak again on "Management of Complications in the Operative and Postoperative Period in COPD including Respiratory Failure"; Dr. Little on "Comments on the Complications in the Postoperative Periods in COPD"; and Dr. Jarrell will conclude this session with "Mechanical Aids."

4:15 Panel Discussion with Dr. Walter S. Dunbar, Moderator, and Drs. Galloway, Bobear, Jarrell and Little as panel members.

6:15 Social Hour and Dinner

Coach Room, Carriage Inn

GEORGIA SOCIETY OF INTERNAL MEDICINE AND GEORGIA CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Thursday, May 7

11:30 Luncheon and Business Meeting

Lounge, Carriage Inn

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Thursday, May 7

1:00 Luncheon and Scientific Meeting

Banquet Room, Wanderer Motel

Dr. S. A. Roddenbery, Columbus, presiding, and a panel of Brunswick surgeons will discuss "Solving Surgical Problems," with a question and answer period to follow.

GEORGIA ASSOCIATION OF PATHOLOGISTS

Thursday, May 7

3:00 Business Meeting

Jekyll Island Golf Club

6:00 Social Hour and Dinner

Sea Island Yacht Club

Whatever practical people may say, this world is, after all, absolutely governed by ideas, and very often by the wildest and most hypothetical ideas.

—Thomas Huxley

ALUMNI EVENTS

EMORY UNIVERSITY SCHOOL OF MEDICINE ALUMNI

Friday, May 8

6:30 Reception and Dinner
Banquet Room, Wanderer Motel

UNIVERSITY OF VIRGINIA MEDICAL ALUMNI

Friday, May 8

6:30 Reception
Buccaneer Room, Buccaneer Motel

MEDICAL COLLEGE OF GEORGIA ALUMNI

Friday, May 8

7:30 Reception and Dinner
Coach Room, Carriage Inn

MEDICAL COLLEGE OF GEORGIA CLASS OF 1945—25TH REUNION

Friday, May 8

8:30 Dinner
Lounge, Carriage Inn

OTHER EVENTS

GEORGIA MEDICAL POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS

Friday, May 8

7:30 Breakfast and Meeting
Conference Room, Corsair Motel

MAG CRIPPLED CHILDREN COMMITTEE

Friday, May 8

5:00 Meeting
Surrey Room, Carriage Inn

MEDICAL COLLEGE OF GEORGIA FOUNDATION BOARD OF TRUSTEES

Saturday, May 9

12:00 Luncheon
Pirates Cove, Buccaneer Motel

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL

February 15, 1970
Sheraton-Biltmore, Atlanta

Appointments—Appointed James M. Skinner, M.D., Griffin, Chairman of the Committee on Hospital Activities, at the suggestion of outgoing Chairman Alex P. Jones, M.D.

Appointed William Huger, Jr., M.D., to the Committee on Medical Review and Negotiating representing specialists in plastic surgery.

Himler Report—Authorized President Train to appoint three Councilors, one of whom is a member of the AMA delegation, to study and make recommendations to Council on this report.

Dues Exempt Members Benefits—Voted to request the Committee on Constitution and Bylaws to develop language for presentation to the House of Delegates which would amend the Bylaws to allow MAG publications to be continued for DE-1 (Financial Hardship or Illness) and Life Members.

Headquarters Office—Voted to continue the night security service for an additional month.

Voted to allow parking leases to be offered for \$10.00 per month in C-Deck.

Voted to request an all-risk insurance endorsement for 31 days, allowing for a decision by Council on purchasing an all-risk policy on the building and contents for an additional \$146.00 annually.

Current Procedure Terminology—Endorsed the new 5-digit coding and nomenclature of procedures as included in AMA's 1970 CPT.

Emory-Grady Contract—Decided to take no action on previous directives to call a hearing until a new contract can be reviewed.

Medicredit—Endorsed the AMA's income tax credit plan to purchase health insurance and referred it to Council for its consideration.

Conference of County Officers—This meeting of the Executive Committee was convened following a Conference for County Society Officers, arranged by the Committee on Public Service. The two day Conference attended by 75 local society officials, was concluded with a stirring address by Mr. Bill Curry, of the Baltimore Colts.

Woman's Auxiliary to the Medical Association of Georgia 45th Annual Convention



PRESIDENT'S GREETING

DOCTORS' WIVES OF GEORGIA, this is an enthusiastic invitation to each of you to attend our 45th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Our gracious hostesses have delightful plans for the entire meeting.

Be with us for a pleasant time of relaxation in this romantic setting when we review our year's activities of projecting auxiliary concern, and as we consider the challenging possibilities of continued assistance to the medical societies of Georgia.

Sincerely,

Mrs. S. William Clark, Jr., *President*
Woman's Auxiliary to the
Medical Association of Georgia

WELCOME TO JEKYLL ISLAND

ON BEHALF of the Glynn County Medical Auxiliary, it is my pleasure and privilege to extend to each of you a most cordial welcome to this 45th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia. We want to assist you in every way possible to make your stay a memorable one. We know that it is during these times of fun, fellowship, and hard work that the doctors and their wives are bound more closely together with those all over our State who share the same interests, beliefs, and goals. Never has this seemed more important. It is our fondest hope that you will find our beloved area truly "Georgia's Land of the Golden Isles."

Cordially,

Mrs. John Lewis Hobson, *President*
Glynn County Medical Auxiliary

THE PROGRAM

THURSDAY, MAY 7

- 9:00 Registration and Information
to Lobby
5:00 Buccaneer Motor Lodge
- 10:00 Hospitality and Exhibits Room
to The Jolly Roger Room
5:00 Buccaneer Motor Lodge
- 11:30 Pre-Convention Executive Board
to Meeting—Dutch Luncheon
1:15 Buccaneer Room
Buccaneer Motor Lodge
- PRESIDING—MRS. S. WILLIAM CLARK, JR., Waycross, *President*, Woman's Auxiliary to the MAG
- INVOCATION—MRS. CHARLES M. WARD, *President*, Randolph-Stewart-Terrell Auxiliary
- PLEDGE OF ALLEGIANCE TO FLAG—MRS. EVANS NICHOLS, Marietta, *Historian*
- PLEDGE OF LOYALTY AND COLLECT—MRS. PHIL C. ASTIN, JR., *President*, Carroll-Douglas-Haralson Auxiliary
- INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. NORMAN B. PURSLEY, Augusta, *First Vice President*
- 1:15 Adjournment
- 1:30 MAG General Session
to Aquarama
- 2:30 (All MAG and Auxiliary Members Invited)
PRESIDING—JOHN KIRK TRAIN, JR., M.D., Savannah, *President*
- 3:30 Guided Lecture and Tour of Fort Frederica by U.S. Park Ranger
- 3:30 Guided Tour of Christ Church and Cemetery, Frederica
- 5:00
- Eve- MAG Specialty Society Receptions
ning and Dinners
(See MAG Program)

FRIDAY, MAY 8

- 8:00 Registration and Information
to Lobby
5:00 Buccaneer Motor Lodge
- Hospitality and Exhibits Room
The Jolly Roger Room
Buccaneer Motor Lodge

9:00 MAG General Business Session and House of Delegates Meeting

Aquarama

(All MAG and Auxiliary Members and Guests Invited)

PRESIDING—JOHN KIRK TRAIN, JR., M.D., Savannah, *President*

REPORT OF WOMAN'S AUXILIARY TO MAG—MRS. CHARLES R. SMITH, Columbus, *President-Elect*

9:00 Auxiliary General Meeting

Buccaneer Room

Buccaneer Motor Lodge

9:15 Call to Order

MRS. S. WILLIAM CLARK, JR., Waycross, *President*

INVOCATION—MRS. PAUL J. PAYNE, *President*, Cobb County Medical Society Auxiliary

PLEDGE OF ALLEGIANCE TO FLAG—MRS. WILLIAM M. HEADLEY, *President*, Baldwin County Auxiliary

PLEDGE OF LOYALTY AND COLLECT—MRS. DAVID DENNISON, *President*, Fulton County Auxiliary

ADDRESS OF WELCOME—MRS. JOHN L. HOBSON, *President*, Glynn County Auxiliary

RESPONSE TO WELCOME—MRS. STEPHEN MULHERIN, *President*, Richmond County Auxiliary

PRESENTATION OF CONVENTION PLANS—MRS. W. JACK SMITH, *Brunswick*, Convention Chairman

INTRODUCTION OF PAGES FOR THE DAY—MRS. ERWIN R. JENNINGS, *Brunswick*

INTRODUCTION OF PAST PRESIDENTS AND GUESTS—MRS. C. JAMES ROPER, Jasper, *Second Vice-President*

Business Session

(All reports limited to two minutes)

CONVENTION RULES OF ORDER—MRS. LOUIE H. GRIFFIN, SR., Claxton, *Parliamentarian*

ROLL CALL AND MINUTES—MRS. JOHN G. BATES, Cuthbert, *Recording Secretary*

TREASURER'S REPORT (Including Auditor's Report)—MRS. HARRY B. O'REAR, Augusta, *Treasurer*

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MAG—W. C. MITCHELL, M.D., *Chairman*, Smyrna

Greetings

PRESIDENT OF MAG—JOHN KIRK TRAIN, JR., M.D., Savannah

PRESIDENT-ELECT OF MAG—F. G. ELDRIDGE, M.D., Valdosta

PRESIDENT'S REPORT—MRS. S. WILLIAM CLARK, JR., Waycross, *President*

PRESIDENT-ELECT'S REPORT—MRS. CHARLES R. SMITH, Columbus, *President-Elect*

ADDENDUM REPORTS—State Officers and Chairmen (Complete reports are published in the 1969-1970 Annual Report Book)

RECOMMENDATIONS FROM THE EXECUTIVE BOARD—MRS. JOHN G. BATES, Cuthbert

REPORT OF THE REVISIONS COMMITTEE—MRS. GEORGE HARRISON, Marietta, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. ROBERT E. PERRY, JR., Brunswick, *Chairman*

11:00 Introduction of Guest Speaker

MRS. JOHN L. HOBSON, *President*, Glynn County Auxiliary

ADDRESS—MRS. JOHN M. CHENAULT, *President*, Woman's Auxiliary to the American Medical Association, Decatur, Alabama

INTRODUCTION OF MAG EXECUTIVE STAFF—MRS. CLARK

Executive Director—MR. EDWIN F. SMITH

Assistant Director, Administration—MRS. CATHERINE L. WOOTEN

ANNOUNCEMENTS

12:00 Recess of Session

12:00 MAG General Session (Abner W. Calhoun Lectureship)

Aquarama

(All MAG and Auxiliary Members and Guests Invited)

12:00 Luncheon and Autograph Party

Special Guests—Members-at-Large, WAMAG

(Luncheon) *Banquet Room*

(Autograph Party) *Mallard Room*
Wanderer Motel

PRESIDING—MRS. S. WILLIAM CLARK, JR., Waycross, *President*

INVOCATION—MRS. JOHN E. PENLAND, Waycross, *Past President*

INTRODUCTION OF PAST PRESIDENTS—MRS. HAYWARD S. PHILLIPS, Augusta, *Immediate Past President*, WAMAG

INTRODUCTION OF GUEST SPEAKER—MRS. C. S. BRITT, Brunswick

SPEAKER—Miss EUGENIA PRICE, Frederica, "Falling in Love With an Island"

Evening

Alumni Receptions and Dinners and Other Alumni Functions (See MAG program)

SATURDAY, MAY 9

8:00 Registration and Information
to Lobby, *Buccaneer Motor Lodge*

5:00

Hospitality and Exhibits

The Jolly Roger Room

Buccaneer Motor Lodge

9:00 Auxiliary General Meeting

Buccaneer Room

Buccaneer Motor Lodge

9:15 Call to Order

MRS. S. WILLIAM CLARK, JR., *President*

INVOCATION—MRS. A. WORTH HOBBY, Atlanta, *Past President*

PLEDGE OF ALLEGIANCE TO FLAG—MRS. DONALD BRANYON, JR., *President*, Crawford W. Long Auxiliary

PLEDGE OF LOYALTY AND COLLECT—MRS. THOMAS J. FERRELL, JR., *President*, Ware County Auxiliary

INTRODUCTION OF PAGES FOR THE DAY—MRS. ERWIN R. JENNINGS, Brunswick

INTRODUCTION OF PAST PRESIDENTS—MRS. Z. SWEENEY SIKES, Macon, *Third Vice President*

CONVENTION ANNOUNCEMENTS—MRS. WILLARD A. SNYDER, Brunswick, *Convention Co-Chairman*

MEMORIAL SERVICE—MRS. MILTON JOHNSON, *President*, Bibb County Auxiliary

MRS. WILLIAM J. BRANAN, JR., *President*, DeKalb County Auxiliary

Soloist—JAMES H. MANNING, M.D., Marietta

Business Session

MINUTES—MRS. JOHN G. BATES, Cuthbert, *Recording Secretary*

REPORT OF THE REVISIONS COMMITTEE—MRS. GEORGE HARRISON, Marietta, *Chairman*

REPORT OF THE BUDGET AND FINANCE COMMITTEE—MRS. PERRY M. WHITE, Atlanta, *Chairman*

REPORT OF THE RESOLUTIONS COMMITTEE—MRS. JAMES H. SULLIVAN, *President*, Muscogee County Auxiliary, *Chairman*

REPORT OF THE CREDENTIALS COMMITTEE—MRS. ROBERT E. PERRY, JR., Brunswick, *Chairman*

REPORT OF THE COURTESY COMMITTEE—MRS. JAMES F. KIRKPATRICK, JR., *President*, Tift County Auxiliary, *Chairman*

REPORTS OF THE AWARDS
COMMITTEES—

Achievement—MRS. GEORGE W. STAT-
HAM, Atlanta, *Chairman*

Safety and Disaster Preparedness—MRS.
ROBERT M. FINE, Decatur, *Chairman*

AMA-ERF—MRS. BENJAMIN BASHIN-
SKI, JR., Macon, *Chairman*

Mrs. J. Bonar White Scrapbook—MRS.
J. ROBERT LOCAN, *President*, Georg-
ia Medical Society Auxiliary, *Chair-
man*

James N. Brawner, Sr., M.D., Awards
for General Excellence—MRS. HAY-
WARD S. PHILLIPS, *Past President*,
Augusta, *Chairman*

Doctor's Day—MRS. J. DANIEL BATE-
MAN, Albany, *Chairman*

REPORT OF MAG CONVENTION—
PRESTON D. ELLINGTON, M.D., *Chair-
man*, MAG Annual Session Committee

REPORT OF NOMINATING COMMIT-
TEE—MRS. HAYWARD S. PHILLIPS,
Augusta, *Chairman*

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS—MRS.
JOHN M. CHENAULT, Decatur, Alabama,
President, Woman's Auxiliary to AMA

INAUGURAL ADDRESS AND AN-
NOUNCEMENTS OF 1970-1971
STATE CHAIRMEN—MRS. CHARLES
R. SMITH, Columbus, *President*

PRESENTATION OF PAST PRESI-
DENT'S PIN—MRS. HAYWARD S. PHIL-
LIPS, Augusta

ANNOUNCEMENTS

12:00 Adjournment

12:30 Sherry Party
The Cloister

**1:00 Luncheon and Fashion Show for
Members and Guests**
Georgian Room
The Cloister

PRESIDING—MRS. CHARLES R. SMITH,
Columbus, *President*

INVOCATION—MRS. NEAL F. YEO-
MANS, Waycross, *Corresponding Secre-
tary*

1:00 Past Presidents' Luncheon (Dutch)
Private Dining Room
The Cloister

PRESIDING—MRS. HAYWARD S. PHIL-
LIPS, *Past President*

**2:00 Self-Guided Walking Tour of Mil-
to lionaire Village, Jekyll Island**
5:00

**6:30 Glynn County Medical Society
Social Hour**
(All MAG Members, Their Wives and
Exhibitors Invited)
Aquarama

8:00 Annual Banquet
Aquarama

SUNDAY, MAY 10

**9:00 Post Convention Executive Board
to Breakfast and School of Instruc-
12:00 tion (Dutch)**

Buccaneer Room
Buccaneer Motor Lodge

PRESIDING—MRS. CHARLES R. SMITH,
Columbus, *President*

**9:00 MAG General Session and Second
Session House of Delegates**
(All MAG and Auxiliary Members and
Guests Invited)
Aquarama

PRESENTATION OF AWARDS
ELECTION AND INSTALLATION OF
OFFICERS

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA 1969-1970

Officers

<i>President</i>	MRS. S. WILLIAM CLARK, JR. 1409 Satilla Boulevard, Waycross, Ga. 31501
<i>President-Elect</i>	MRS. CHARLES R. SMITH 2620 Foley Drive, Columbus, Ga. 31906
<i>First Vice-President</i>	MRS. NORMAN B. PURSLEY 3427 Old Savannah Road, Augusta, Ga. 30906
<i>Second Vice-President</i>	MRS. C. JAMES ROPER 992 South Main Street, Jasper, Ga. 30143
<i>Third Vice-President</i>	MRS. Z. SWEENEY SIKES 259 Idle Wild Road, Macon, Ga. 31204
<i>Recording Secretary</i>	MRS. JOHN BATES 515 Court Street, Cuthbert, Ga. 31740
<i>Corresponding Secretary</i>	MRS. NEAL F. YEOMANS 704 Magnolia Street, Waycross, Ga. 31501
<i>Treasurer</i>	MRS. HARRY B. O'REAR 3069 Hillsdale Drive, Augusta, Ga. 30904
<i>Historian</i>	MRS. EVANS NICHOLS 580 Hillandale Circle, Marietta, Ga. 30060
<i>Parliamentarian</i>	MRS. LOUIE H. GRIFFIN P.O. Box 547 Claxton, Ga. 30417

Chairmen of Standing Committees

<i>Achievement Awards</i>	MRS. GEORGE W. STATHAM 3003 Rivermeade Drive, N.W., Atlanta, Ga. 30327
<i>AMA-ERF</i>	MRS. BENJAMIN BASHINSKI, JR. 445 Lamar Drive, Macon, Ga. 31204
<i>AMA-ERF (Co-Chairman)</i>	MRS. WILLIAM D. LOGAN 2072 Imperial Drive, N.E., Atlanta, Ga. 30329
<i>Archives</i>	MRS. PRENTISS E. PARKER 134 McDonald Street, Marietta, Ga. 30060
<i>James N. Brawner, Sr., M.D. Trophy</i>	MRS. HAYWARD S. PHILLIPS 1082 Bertram Road, Augusta, Ga. 30904
<i>Budget and Finance</i>	MRS. PERRY M. WHITE 1547 Cave Road, N.W., Atlanta, Ga. 30327
<i>Children and Youth</i>	MRS. ROBERT M. FLOWERS 1233 Forest Avenue, Columbus, Ga. 31906
<i>Community Health</i>	MRS. LEONARD BROWN 1050 Mountain Creek Trail, Atlanta, Ga. 30329
<i>Doctor's Day</i>	MRS. J. DANIEL BATEMAN 2105 Beattie Road, Albany, Ga. 31701
<i>Editorial (Pulse Line)</i>	MRS. PIERRE N. LEVIN Apartment 15, 135 Hill Street, Decatur, Ga. 30030
<i>Health Careers</i>	MRS. IVAN LEE PEACOCKE 1821 Angélique Drive, Decatur, Ga. 30033
<i>Health Careers (Co-Chairman)</i>	MRS. PAUL W. LUCAS 617 Wilson Street, Tifton, Ga. 31794
<i>Home-Centered Health Care</i>	MRS. CLIFF MOORE, JR. 115 Saddle Mountain Road, Rome, Ga. 30161
<i>International Health Activities</i>	MRS. ALBERTO C. MARTINEZ P.O. Box 677, Milledgeville, Ga. 31061
<i>Legislation</i>	MRS. Z. SWEENEY SIKES 259 Idle Wild Road, Macon, Ga. 31204
<i>Membership</i>	MRS. NORMAN B. PURSLEY 3427 Old Savannah Road, Augusta, Ga. 30906
<i>Membership-at-Large</i>	MRS. EARL T. MCGHEE 808 Atkinson Drive, Dalton, Ga. 30720
<i>Mental Health</i>	MRS. RUSSELL E. ANDREWS, JR. Route 6, Kingston Road, Rome, Ga. 30161
<i>Program</i>	MRS. C. JAMES ROPER 992 South Main Street, Jasper, Ga. 30143
<i>Revisions</i>	MRS. GEORGE HARRISON 576 Pickett Road, S.W., Marietta, Ga. 30060
<i>Revisions (Co-Chairman)</i>	MRS. JAMES H. MANNING 643 Kennesaw Avenue, Marietta, Ga. 30060
<i>Research and Romance of Medicine</i>	MRS. EDWIN H. GRANT Route 1, Carrollton, Ga. 30117
<i>Rural Health</i>	MRS. JAMES HUBERT MILFORD Old Anderson Road, Hartwell, Ga. 30643
<i>Safety-Disaster Preparedness</i>	MRS. ROBERT M. FINE 2025 Breckenridge Drive, N.E., Atlanta, Ga. 30329
<i>Scrapbook</i>	MRS. J. ROBERT LOGAN 202 E. 44th Street, Savannah, Ga. 31405
<i>William R. Dancy, M.D., Student Loan Fund</i>	MRS. WILLIAM N. AGOSTAS 2302 Overton Road, Augusta, Ga. 30904
<i>William R. Dancy, M.D., Student Loan Fund (Co-Chairman)</i>	MRS. JACK B. LINDLEY 2219 Glendale Road, Augusta, Ga. 30904

Chairmen of Special Committees

<i>Crawford W. Long Notepaper</i>	MRS. W. JACK SMITH Country Club Park, Brunswick, Ga. 31520
<i>Woman's Auxiliary to Student American Medical Association (WA-SAMA) Liaison</i>	MRS. F. JAMES FUNK, JR. 3407 Woodhaven Road, N.W., Atlanta, Ga. 30305
<i>WA-SAMA Co-Liaison</i>	MRS. HENRY D. SCOGGINS 3107 Vassar Drive, Augusta, Ga. 30904
<i>GAMPAC Representative</i>	MRS. LUTHER M. VINTON, JR. 1043 Lakeshore Drive, Avondale Estates, Ga. 30002

Councilor to Southern Medical Association

MRS. HAYWARD S. PHILLIPS
1082 Bertram Road, Augusta, Ga. 30904

District Councilors

<i>First District</i>	MRS. JOHN D. McARTHUR Lexington Street, Lyons, Ga. 30436
<i>Second District</i>	MRS. FRED L. NELSON, JR. 803 West Eighth Street, Tifton, Ga. 31794
<i>Third District</i>	MRS. DAN CALLAHAN 119 Sandra Avenue, Warner Robins, Ga. 31093
<i>Sixth District</i>	MRS. MAX MASS 3844 The Prado, Macon, Ga. 31204
<i>Seventh District</i>	MRS. R. D. WALTER Calhoun, Ga. 30701
<i>Eighth District</i>	MRS. RICHARD L. NUTT 605 Mack Drive, Valdosta, Ga. 31601
<i>Ninth District</i>	MRS. C. JAMES ROPER 992 South Main Street, Jasper, Ga. 30143
<i>Tenth District</i>	MRS. RONALD F. GALLOWAY 818 Windsor Court, Augusta, Ga. 30904

Advisory Committee from the Medical Association of Georgia

W. C. Mitchell, M.D., <i>Chairman</i>	104 Sunset Avenue, Smyrna, Ga. 30080
John Kirk Train, Jr., M.D., <i>Ex-Officio</i>	1107 Bull Street, Savannah, Ga. 31401
F. G. Eldridge, M.D., <i>Ex-Officio</i>	Doctors Building, Valdosta, Ga. 31601
Braswell E. Collins, M.D., <i>Liaison, AMA-ERF</i>	740 Hemlock Street, Macon, Ga. 31204
Charles R. Andrews, Jr., M.D.	201 Park View Drive, Canton, Ga. 30114
C. E. Bohler, M.D.	Box 8, Brooklet, Ga. 30415
S. William Clark, Jr., M.D.	P.O. Box 951, Waycross, Ga. 31501
Louie H. Griffin, Sr., M.D.	P.O. Box 547, Claxton, Ga. 30417

The Medical Association of Georgia Related Committees

<i>Allied Health Careers</i>	John T. Godwin, M.D., <i>Chairman</i> 265 Ivy Street, N.E., Atlanta, Ga. 30303
<i>Disaster Medical Care</i>	Virgil B. Williams, M.D., <i>Chairman</i> 571 S. 9th Street, Griffin, Ga. 30223
<i>Legislation</i>	J. Frank Walker, M.D., and Harrison L. Rogers, M.D., <i>Chairmen</i> 1293 Peachtree Street, N.E., Atlanta, Ga. 30309
<i>Mental Health</i>	A. S. Yochem, M.D., <i>Chairman</i> 490 Peachtree Street, N.E., Atlanta, Ga. 30308
<i>Rural Health</i>	Thomas N. Lumsden, M.D., <i>Chairman</i> P.O. Box 297, Clarkesville, Ga. 30523

County Presidents and Presidents-Elect 1969-1970

<i>Baldwin</i>	President, Mrs. William M. Headley 1648 Stone Meadow Road, Milledgeville, Ga. 31061 President-Elect, Mrs. Jose Mendoza Central State Hospital, Milledgeville, Ga. 31062
<i>Bibb</i>	President, Mrs. Milton Johnson 3017 Stuart Drive, Macon, Ga. 31204 President-Elect, Mrs. H. Chandler White, Jr. 3072 Ashby Drive, Macon, Ga. 31204
<i>Carroll-Douglas-Haralson</i>	President, Mrs. Phil C. Astin, Jr. 100 Rennington, Carrollton, Ga. 30117 President-Elect, Mrs. Jack L. Crews 302 West Lake Drive, Carrollton, Ga. 30117
<i>Cherokee-Pickens</i>	President, Mrs. Charles R. Andrews, Jr. 201 Park View Drive, Canton, Ga. 30114 President-Elect, Mrs. William H. Nichols Sunset Drive, Canton, Ga. 30114
<i>Clarke</i>	President, Mrs. Donald Branyon, Jr. 150 Pine Valley Place, Athens, Ga. 30601 President-Elect, Mrs. Royce Banister 40 Pine Valley Drive, Athens, Ga. 30601
<i>Cobb</i>	President, Mrs. Paul J. Payne 552 Wood Valley Drive, Marietta, Ga. 30060 President-Elect, Mrs. Luther G. Fortson 563 Bouldercrest Drive, Marietta, Ga. 30060
<i>Coffee</i>	President, Mrs. Calvin S. Mceks, Jr. Ocilla Road, Douglas, Ga. 31533 President-Elect, Mrs. E. D. Bell Ocilla Road, Douglas, Ga. 31533

<i>Decatur-Seminole</i>	President, Mrs. Wilton Reynolds Route 3, Box 69 E., Donalsonville, Ga. 31745 President-Elect, Mrs. Charles Walker 211 Crawford Street, Donalsonville, Ga. 31745	<i>Tift</i>	President, Mrs. James F. Kirkpatrick, Jr. 113 Carolina Drive, Tifton, Ga. 31794 President-Elect, Mrs. Don Smith 814 W. 22nd Street, Tifton, Ga. 31794
<i>DeKalb</i>	President, Mrs. William J. Branan, Jr. 2592 River Oak Drive, Decatur, Ga. 30033 President-Elect, Mrs. David L. Morgan 2295 Sagamore Hills Drive, Decatur, Ga. 30033	<i>Troup-Heard</i>	President, Mrs. Alvah Nelson Gordon Street, LaGrange, Ga. 30240 President-Elect (None)
<i>Dougherty</i>	President, Mrs. Otis J. Woodard, Jr. 1301 Pinecrest Drive, Albany, Ga. 31705 President-Elect, Mrs. Maxwell J. Sweat, Jr. 2405 Doncaster Drive, Albany, Ga. 31705	<i>Upton</i>	President, Mrs. H. F. Anthony, Jr. 712 S. Center Street, Thomaston, Ga. 30286 President-Elect, Mrs. A. M. Holloway, Jr. 428 Howell Street, Thomaston, Ga. 30286
<i>Elbert-Franklin-Hurt</i>	President, Mrs. Robert F. Sullivan Box 188, Carnesville, Ga. 30521 President-Elect, Mrs. Harold E. Campbell 249 Brookwood Circle, Elberton, Ga. 30635	<i>Walker-Catoosa-Dade</i>	President, Mrs. Garland E. Kinard Chickamauga, Ga. 30707 President-Elect, Mrs. Howard C. Derrick, Jr. 502 Cherokee Street, LaFayette, Ga. 30728
<i>Flint</i>	President, Mrs. John B. Adams 1501 Pine Acres Drive, Cordele, Ga. 31015 President-Elect (None)	<i>Ware</i>	President, Mrs. Thomas J. Ferrell, Jr. 1212 Pruitt Drive, Waycross, Ga. 31501 President-Elect, Mrs. Michael Stebler 1313 Carswell Avenue, Waycross, Ga. 31501
<i>Floyd</i>	President, Mrs. Jack Waldrep 201 Greenview Road, Rome, Ga. 30161 President-Elect, Mrs. Sam Garner 210 West Lakeshore Drive, Rome, Ga. 30161	<i>Whitfield-Murray</i>	President, Mrs. Victor Dardin Emerald Apt., Tibbs Road, Dalton, Ga. 30720 President-Elect, Mrs. Thomas Fulghum 615 S. Thornton Ave., Dalton, Ga. 30720
<i>Fulton</i>	President, Mrs. David Dennison 3929 Tuxedo Road, N.W., Atlanta, Ga. 30305 President-Elect, Mrs. Milton Satcher 3512 Herschel Road, College Park, Ga. 30337	<i>Worth</i>	President, Mrs. M. L. Tracy, Jr. 508 N. Main Street, Sylvester, Ga. 31791 President-Elect, Mrs. H. Gordon Davis, Jr. King Street, Sylvester, Ga. 31791
<i>Georgia Medical Society</i>	President, Mrs. J. Robert Logan 202 E. 44th Street, Savannah, Ga. 31405 First Vice President, Mrs. J. Reid Broderick 324 E. 46th Street, Savannah, Ga. 31405	<h2>Past Presidents and Conventions</h2> <h3>Honorary Presidents for Life</h3> <p>Mrs. James N. Brawner, Sr., Atlanta (Deceased) Mrs. Eustace A. Allen, Atlanta Mrs. William R. Dancy, Savannah Mrs. Ralph H. Chaney, Sr., Augusta</p>	
<i>Glynn</i>	President, Mrs. John L. Hobson 4003 Riverside Drive, Brunswick, Ga. 31520 President-Elect, Mrs. Hurley D. Jones 4036 Riverside Drive, Brunswick, Ga. 31520		
<i>Gordon</i>	President, Mrs. J. LeRoy Rabb 106 Hillcrest Drive, Calhoun, Ga. 30701 President-Elect, Mrs. Joseph Bishop Rome Road, Calhoun, Ga. 30701	<p>1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta (Deceased), Temporary Chairman 1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta (Deceased) 1926—Albany—Mrs. William H. Myers, Savannah (Deceased) 1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased) 1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S.C.) 1929—Macon—Mrs. Charles C. Hinton, Macon 1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased) 1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased) 1932—Savannah—Mrs. Ralston Latimore, Savannah 1933—Macon—Mrs. S. T. R. Revell, Louisville 1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased) 1935—Atlanta—Mrs. J. E. Penland, Waycross 1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased) 1937—Macon—Mrs. W. R. Dancy, Savannah 1938—Augusta—Mrs. Ralph H. Chaney, Sr., Augusta 1939—Atlanta—Mrs. Warren A. Coleman, Eastman 1940—Savannah—Mrs. Eustace A. Allen, Atlanta 1941—Macon—Mrs. H. G. Bannister, Ila 1942—Augusta—Mrs. Lee Howard, Savannah 1943—Atlanta—Mrs. J. Lon King, Macon 1944—Savannah—Mrs. Olin S. Cofer, Atlanta 1945—No Convention 1946—Macon—Mrs. W. T. Randolph, Winder 1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa 1948—Atlanta—Mrs. W. G. Elliott, Cuthbert 1949—Savannah—Mrs. S. A. Anderson, Atlanta 1950—Macon—Mrs. J. Harry Rogers, Atlanta 1951—Augusta—Mrs. Lehman W. Williams, Savannah 1952—Atlanta—Mrs. J. R. S. Mays, Macon 1953—Savannah—Mrs. Ralph W. Fowler, Marietta (Deceased) 1954—Macon—Mrs. Leo Smith, Waycross 1955—Augusta—Mrs. Shelley C. Davis, Atlanta 1956—Atlanta—Mrs. Robert C. Major, Augusta 1957—Savannah—Mrs. Walker L. Curtis, College Park 1958—Macon—Mrs. John L. Elliott, Savannah 1959—Augusta—Mrs. Luther H. Wolff, Columbus 1960—Columbus—Mrs. Remer Y. Clark, Marietta 1961—Atlanta—Mrs. W. P. Rhyné, Albany 1962—Savannah—Mrs. A. Worth Hobby, Atlanta 1963—Jekyll Island—Mrs. E. W. Waldemayer, Chamblee 1964—Macon—Mrs. John E. Porter, Savannah 1965—Augusta—Mrs. John T. Leslie, Avondale Estates 1966—Columbus—Mrs. Louie H. Griffin, Sr., Claxton 1967—Atlanta—Mrs. John Meier, Albany 1968—Augusta—Mrs. James H. Manning, Marietta 1969—Savannah—Mrs. Hayward S. Phillips, Augusta</p>	
<i>Hall-Lumpkin</i>	President, Mrs. W. C. Ferrell 1352 Burns Drive, N.E., Gainesville, Ga. 30501 President-Elect (None)		
<i>Mitchell</i>	President, Mrs. C. L. Howard 140 Barrow Avenue, Pelham, Ga. 31779 President-Elect (None)		
<i>Muscogee</i>	President, Mrs. James H. Sullivan 2519 Craigston Drive, Columbus, Ga. 31906 President-Elect, Mrs. William M. Taylor 2204 Downing Drive, Columbus, Ga. 31906		
<i>Ogeechee River</i>	President, Mrs. Leon E. Curry 430 Williams Street, Metter, Ga. 30439 President-Elect, Mrs. Louie H. Griffin Box 547, Claxton, Ga. 30417		
<i>Peach Belt</i>	President, Mrs. John R. Arnall Elenor Circle, Perry, Ga. 31069 President-Elect (None)		
<i>Randolph-Stewart-Terrell</i>	President, Mrs. Charles M. Ward Dawson, Ga. 31742 President-Elect, Mrs. Carl E. Sills Cuthbert, Ga. 31740		
<i>Richmond</i>	President, Mrs. Stephen Mulherin 2233 Kings Way, Augusta, Ga. 30904 President-Elect, Mrs. Herbert Harper 996 Campbellton Drive, North Augusta, S.C. 29841		
<i>South Georgia</i>	President, Mrs. Joseph H. Brannen 2803 Country Club Drive, Valdosta, Ga. 31601 President-Elect, Mrs. Dewey Lockwood Barton 2510 Winding Way, Valdosta, Ga. 31601		
<i>Southeast Georgia</i>	President, Mrs. W. W. Akin North Lanier Street, Lyons, Ga. 30436 President-Elect (None)		
<i>Southwest Georgia</i>	President, Mrs. Homer P. Wood Fort Gaines, Ga. 31751 President-Elect (None)		
<i>Stephens</i>	President, Mrs. Kenneth Conoley 831 Rosedale Lane, Toccoa, Ga. 30577 President-Elect (None)		
<i>Sumter-Schley-Macon</i>	President, Mrs. Harvey L. Simpson, Jr. Eckles Road, Americus, Ga. 31709 President-Elect, Mrs. L. S. Boyette Ellaville, Ga. 31806		
<i>Thomas Brooks</i>	President, Mrs. John T. King, Jr. 109 Pastime Drive, Thomasville, Ga. 31792 President-Elect (None)		

CONVENTION COMMITTEES

General Chairman

Mrs. W. Jack Smith

Co-Chairman

Mrs. Willard A. Snyder

Registration and Credentials

Mrs. Robert E. Perry, Jr.

Tellers

Mrs. Garland E. Kinard, Chickamauga
Mrs. H. F. Anthony, Jr., Thomaston
Mrs. Kenneth Conoley, Toccoa

Timekeepers

Mrs. Otis J. Woodard, Jr., Albany
Mrs. J. Robert Logan, Savannah

Reading Committee

Mrs. Earl T. McGhee, Dalton
Mrs. James H. Manning, Marietta
Mrs. Jack Waldrep, Rome

Art Committee

Mrs. Marvin F. Engel

Publicity

Mrs. Robert H. Thompson

Memorial Service

Mrs. Milton Johnson, Macon
Mrs. William J. Branan, Jr., Decatur

Resolutions Committee

Mrs. James H. Sullivan, Columbus
Mrs. John R. Arnall, Perry

Courtesy Committee

Mrs. James F. Kirkpatrick, Jr., Tifton
Mrs. Calvin F. Meeks, Jr., Douglas

Hospitality Committee

Mrs. John Lewis Hobson
Mrs. Newell Hamilton

Display Room

Mrs. William F. Austin

Pages

Mrs. Erwin R. Jennings

Information

Mrs. Benjamin A. Addison

Favors

Mrs. Don R. Roberts

Flowers

Mrs. James M. Hicks

Transportation

Mrs. Milledge G. Smith

Executive Board Pre-Convention Luncheon

Mrs. Haywood L. Moore

Friday Luncheon and Autograph Party

Mrs. J. L. Owens, Jr.

Saturday Luncheon and Fashion Show

Mrs. C. S. Britt, Chairman
Mrs. J. L. Hunt, Co-Chairman

Past President's Luncheon

Mrs. Hurley D. Jones

Post-Convention Breakfast and School of Instruction

Mrs. Bert H. Malone

President's Banquet and Luau

Mrs. Michael A. Glucksman

CALENDAR OF MEETINGS

In Georgia

- April 6-7—The Role of the Nurse Midwife in American Obstetrics, Grady Memorial Hospital, Atlanta.
April 8-12—The James Ewing Society, Regency Hyatt House, Atlanta.
April 18-23—Southeastern Surgical Congress, 38th Annual Assembly, Marriott Motor Hotel, Atlanta.
April 19-23—National Commission for the Study of Nursing and Nursing Education, American Motor Hotel, Atlanta.

In the Nation

- April 1-4—American Association for the History of Medicine, Birmingham, Ala.
April 3-4—American Geriatrics Society, Americana Hotel, New York, N.Y.
April 6-8—American Association for Thoracic Surgery, Washington Hilton Hotel, Washington, D.C.
April 9-10—American Society for Artificial Internal Organs, Washington-Hilton Hotel, Washington, D.C.
April 9-10—American Association of Planned Parenthood Physicians, Statler Hilton Hotel, Boston, Mass.
April 9-10—Conference on Metabolism and Biological Functions of Polyamines, Waldorf Astoria Hotel, New York, N.Y.
April 9-10—National Conference on Rural Health, Pfister Hotel and Tower, Milwaukee, Wis.
April 9-11—Current Concepts in Physiology of the Gastrointestinal, Endocrine, and Respiratory Systems, Holiday Inn, Philadelphia, Penn.
April 9-15—American Leprosy Missions Seminar, U.S. Public Health Service Hospital, Carville, La.
April 10-11—American Burn Association, Sheraton Boston Hotel, Boston, Mass.
April 10-12—American Society of Internal Medicine, Warwick Hotel, Philadelphia, Penn.
April 12-18—American College of Obstetricians and Gynecologists, Americana Hotel, New York, N.Y.
April 12-17—American College of Physicians, Bellevue Stratford Hotel, Philadelphia, Penn.
April 12-16—American Medical Tennis Association, Palm Springs, Calif.
April 12-17—American Physiological Society, Holiday Inn, Atlantic City, N.J.
April 12-17—American Society for Experimental Pathology, Atlantic City, N.J.
April 13-16—American Academy of Pediatrics, Washington-Hilton Hotel, Washington, D.C.
April 13-17—American Society for Pharmacology and Experimental Therapeutics, Hotel Dennis, Atlantic City, N.J.
April 13-16—Industrial Medical Association, Palmer House, Chicago, Ill.
April 14-17—American College Health Association, Statler-Hilton Hotel, Boston, Mass.
April 15-18—American Cleft Palate Association, Portland-Hilton Hotel, Portland, Ore.
April 16-17—American Association of Railway Surgeons, Drake Hotel, Chicago, Ill.
April 19-23—American Association of Neurological Surgeons, Shoreham Hotel, Washington, D.C.
April 29-May 2—American Pediatric Society, Traymore Hotel, Atlantic City, N.J.



*Shuttle Bus:
(Bus leaves from
the hotels marked
with Asterisk).
Schedule to be published
in JMAG Program Issue
March 1970.



JEKYLL ISLAND

Points of Interest and Convenience

1. Shopping center, Authority office, post office, police.
- *2. Aquarama containing 2,500 seat convention hall with indoor heated pool.
3. South public bath house.
- *4. Corsair Motel and Restaurant.
- *5. Buccaneer Motel and Restaurant.
- *6. Carriage Inn Motel and Restaurant.
7. South picnic area.
8. Parking area.
9. Beach concession stand.
10. Ocean-side golf course.
11. Golf clubhouse and miniature golf course.
12. Eighteen-hole championship golf course.
13. Beach walk—1¼ miles fronting ocean.
14. North public bath house.
15. Beach concession stand.
- *16. Wanderer Motel and Restaurant.
- *17. Jekyll Estates Motel.
18. Oakgrove residential area.
19. Palmetto residential area.
20. Jekyll Beach residential area.
21. North picnic area.
22. Cherokee Campground.
23. Driftwood Beach.
24. Clam Creek fishing and picnic area.
25. Ruins of Major Horton's House.
26. Historical DuBignon Cemetery.
27. Ruins of Georgia's first brewery.
28. Picnic Area.
29. Plantation residential area.
30. Paved airstrip.
31. Pinegrove residential area.
32. Auditorium.
33. Faith Chapel.
34. All-weather tennis courts and clubhouse.
35. Jekyll Club Hotel and Village Area.
36. Jekyll Island Marina and boat docks.
37. Jekyll Island Museum.
38. Picnic Area.
39. St. Andrews residential area.
40. Miniature golf course.
41. Proposed Teen Center.
42. Beach casino and recreational area.
43. St. Andrews Auditorium.
44. Proposed yacht basin.
- *45. Seafarer.

1970 SHUTTLE BUS SCHEDULE MAY 7, 8, 9 AND SUNDAY, MAY 10

LEAVING TIMES FROM LOCATIONS AS INDICATED

Thursday, Friday, Saturday

Wanderer	Stuckey's
Seafarer	Carriage
Jekyll Estates	Inn
<i>Leaving</i>	<i>Leaving</i>
7:30 a.m.	7:45 a.m.
8:00	8:15
8:30	8:45
9:00	9:15
9:30	9:45
10:00	10:15
10:30	10:45
11:00	11:15
11:30	11:45
12:01 p.m.	12:15 p.m.

Lunch Break Coach Operator 12:15 p.m.—1:15 p.m.

1:30 p.m.	1:15 p.m.
2:00	1:45
2:30	2:15
3:00	2:45
3:30	3:15
4:00	3:45
4:30	4:15
5:00	4:45
5:30	5:15
6:00	5:45
	6:15

(End Service for Day
at the Wanderer 6:30 p.m.)

Sunday, May 10

Wanderer	Stuckey's
Seafarer	Carriage
Jekyll Estates	Inn
<i>Leaving</i>	<i>Leaving</i>
8:30 a.m.	8:45 a.m.
9:00	9:15
9:30	9:45
10:00	10:15
10:30	10:45
11:00	11:15
11:30	11:45
12:01 p.m.	12:15 p.m.

(End Sunday Service)
(At Wanderer 12:30 p.m.)

Medical Association of Georgia

Annual Session

May 7-10, 1970—Jekyll Island, Georgia

RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
(Motel of your choice)
Jekyll Island, Ga. 31520
2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible confirmation will be in accordance with preference indicated, if not, best substitute will be made.
4. Unreserved accommodations will be released on April 23, 1970.
5. A deposit in the amount of one night's lodging, plus 3% Georgia State sales tax, is required to assure your reservation. Make check payable to motel of your choice.
6. Rooms will not be ready for occupancy until 3:00 p.m. on day of arrival. Check-out time is 12:00 noon on your departure date.
7. A quick check out card will be placed in each room. Turn this in at Registration Desk and you will be billed later.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Name of Motel		Bedroom 1-2 persons	Kitchenette 1-2 persons	Each Additional Person
Buccaneer Motor Lodge	(Ocean)	\$17-20	\$20-24	\$1.00
	(Court)	\$16-18	\$18.00	\$1.00
Corsair Motel	(Ocean)	\$21.00	\$22.00	\$2.00
	(Drive)	\$18.00	\$19.00	\$2.00
Stuckey's Carriage Inn	(Pool)	\$21.00		\$2.00
	(Drive)	\$19.00		\$2.00
Wanderer Motel	(Ocean)	\$20.00	\$21-26	\$2.00
	(Drive)	\$17.00		\$2.00
Seafarer Motel	(Drive)	\$14.00	\$16.00	
Jekyll Estates Motel	(Ocean)	\$18.00		

ALL RATES PLUS 3% GEORGIA STATE SALES TAX

Cut out and send to motel of your choice:

Please type or print

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION

MAY 7-10, 1970

NAME

ADDRESS

CITY & STATE ZIP

ARRIVAL DATE DEPARTURE DATE

I DESIRE ACCOMMODATIONS AT (1st) (2nd) MOTEL.....

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS

I DESIRE TRANSPORTATION FROM TO MOTEL

FLIGHT # TIME

Ophthalmology, unlike many other fields of medicine, lends itself readily to the type of recording necessary for computerization of medical records.

Use of Computer in the Study of Retinal Disease and Retinal Detachment

WILLIAM S. HAGLER, M.D., WILLIAM H. JARRETT, M.D., and
GEORGE D. PRESLEY, M.D., *Atlanta*

COMPUTERS ARE ACQUIRING an ever-increasing role in medicine today. At the present time, they are finding application in 1) medical diagnosis, 2) medical records, 3) laboratory analyses, 4) patient monitoring, 5) hospital communications, and 6) utilization of hospital facilities.¹

Another area in which the computer is becoming of increasing usefulness is in medical research. The mode of applications in this field is in the storage, rapid retrieval, and immediate analysis of information.² In order for the operations above to be successfully carried out, data must be converted into a machine-readable form and this at times has proven to be a rather difficult and laborious task.

A medical record is a vast storehouse of information and source of data for analysis and study of specific disease processes which is particularly useful when large numbers of patients with specific diseases are available for study. In the present study, we have elected to use a check list for processing of medical records. The information is then transferred to punch cards and thence to magnetic tape for storage, retrieval and analysis by the computer.

The present report is intended only to illustrate the form developed by the authors and to show some of the various types of information retrieval that may be carried out when patients with different types of retinal disease and retinal detachments are studied. The results of the various types of surgery carried out for these conditions can be analyzed for percentage cure, complications, visual results, and numerous other parameters. Various

computer programs for studying the statistical significance of this data are already available, and thus the surgeon can evaluate the effectiveness of a given surgical technique at any time.

Method

With the help of the Emory University Department of Statistics and Biometry, a check list for the coding of medical records on patients seen on the retina service of Emory University Clinic was devised. This list is quite comprehensive with the initial portion dealing in general information, such as identification of the patient, age, sex, race, and eye involved. In addition to the above, various pertinent points in the history and examination that are thought to relate to retinal detachment or retinal disease have been reduced to check list questions which can later be analyzed by use of the computer. All of the factors that can be determined by present methods of examination are included. Specifically, the level of intraocular pressure, the state of the vitreous, the clarity of the lens, the type, size, shape, number, and location of the retinal tears, the appearance of the macula and the refractive error are recorded on every patient.

Information on the methods of treatment utilized and the results obtained are also coded and may be correlated with the type of detachment present and the many other pre-existing conditions. Also, we have incorporated specific questions concerning the condition of the fellow eye, and this can again be correlated with any of the above-mentioned information. Eventually, all records on the some 3,000 patients with retinal detachment previously operated on by us will be transferred into check list form for study, but at the present time, we have

Presented at the 115th Annual Session of the Medical Association of Georgia, May, 1969, Savannah.

coded out only 370 records on which we have carried out various preliminary sample analyses.

Table I, which is the actual computer print-out on this series, defines the two groups of patients studied. The groups treated by both diathermy and cryocauterization are broken down into race and sex, as well as into the distribution in age by decades. Notice that the percentage cure rate is analyzed for each classification and that it varies from a low of 66 per cent to a high of 100 per cent. Due to the small size of this sample, statistical studies as to the significance of the variation in cure rate have not yet been analyzed. It is interesting to note, however, that the cure rate is certainly not significantly lower in the older age groups. It is most interesting to note that the overall rate of cure is exactly the same in those patients treated with diathermy as compared with those treated with cryocauterization.

TABLE I							
<hr/>							
Patients receiving surgery	115	100.0	91.3	255	100.0	91.0	
Distribution by sex							
Female	58	50.4	89.7	104	40.8	94.2	
Male	54	47.0	92.6	137	53.7	87.6	
<hr/>							
Distribution by age (years)							
1-10	4	3.5	100.0	6	2.4	66.7	
11-20	8	7.0	100.0	16	6.3	87.5	
21-30	4	3.5	75.0	17	6.7	82.4	
31-40	7	6.1	85.7	15	5.9	93.3	
41-50	9	7.8	88.9	39	15.3	92.3	
51-60	30	26.1	96.7	64	25.1	93.8	
61-70	36	31.3	91.7	69	27.1	92.8	
Over 70	14	12.2	78.6	23	9.0	87.0	
<hr/>							
Distribution by race							
Caucasian	110	95.7	90.9	243	95.3	91.4	
Negro	2	1.7	100.0	6	2.4	83.3	

Complication Rate

Many authors have been interested in determining the rate of complications in patients treated with cryocauterization compared with those treated with diathermy. Contradictory statements have appeared in the literature and, in fact, one of the main reasons we undertook this study was to determine which surgical method produced the least number of complications and the highest rate of cure. Table II shows how the major types of complications can be easily identified and analyzed and we feel we will be able to draw very valid conclusions once the size of our sample has been enlarged. It is most interesting, however, that from this preliminary report one notes that the incidence of the major hemorrhagic complications, choroidal hemorrhage, choroidal detachment and subretinal hemorrhage, are essentially the same in both groups of patients. At one

time we were actually under the impression that in our own hands these hemorrhagic complications were much greater in patients treated with cryo and we had even considered abandoning cryocauterization at one point because of this. This analysis simply proves that one's impression cannot be relied upon to make such a major pronouncement in judgment and that one must rely on more accurate statistical studies and not on one's clinical impression.

TABLE II								
Complications			Rate			Rate		
Choroidal hemorrhage	.....	4	3.5	50.0	4	1.6	75.0	
Choroidal detachment	.....	14	12.2	85.7	29	11.4	93.1	
Subretinal hemorrhage	....	7	6.1	85.7	19	7.5	100.0	
Diplopia	.....	0			1	.4	100.0	
Macula pucker	.....	5	4.3	80.0	4	1.6	100.0	
MVR	.....	2	1.7	100.0	1	.4		
Extrusion implant	.....	0			0			
Intrusion of implant	.....	1	.9	100.0	2	.8	100.0	
Pigment fallout	.....	0			6	2.4	100.0	

Findings concerning the percentage cure rate associated with numerous preoperative conditions have also been studied. The cure rate or rate of reattachment has been noted at both three and six months. This cure rate was then determined in both phakic and aphakic eyes at three and six months post-operatively and this was related to the duration of the detachment and the number and types of breaks present.

Comment

Ophthalmology, unlike many other fields of medicine, lends itself readily to the type of recording necessary for computerization of medical records. This is possible since many findings are recorded in standard numerical terms, e.g., visual acuity, measurements of angle of squint, and intraocular pressures. However, in many areas it lacks this standardization which is so convenient in computerization and falls back on written description and, especially in the areas of retinal disease, on detailed color coded drawings of fundus findings.

The check list which we have devised is quite comprehensive in its scope but at times it is found to be lacking in some data which has been considered important in certain individual cases. However, if this type of input system is to be utilized, a certain awareness of abbreviation and/or deletion of certain data must be under such broad categories as *other* fundus changes or findings. Only an ophthalmologist trained in retinal detachment can interpret the fundus drawings accurately enough to transcribe data onto the check list and this is, unfortunately, fairly time-consuming.

It is especially important to analyze all factors in disease processes such as retinal detachment since this is a disorder of unknown etiology. If enough data on enough patients are analyzed carefully, the computer analysis may eventually give us some clue as to the cause of this blinding disorder.

Technique Explosion

There has been a literal explosion of techniques for treatment and prevention of retinal detachment over the past two years. Partial and encircling scleral bucklings have been introduced, performed with either polyethylene, solid or sponge silicone, preserved fascia lata, gel-film or preserved human sclera. These procedures are used with either diathermy, photocoagulation, Laser coagulation or cryocoagulation. The vitreous may be transplanted with saline, air, silicone, or human vitreous. Obviously the combination of the above techniques is almost endless and each has its enthusiastic supporters. It will only be by the careful analysis of advantages, cure rates, and complications that the best technique for a given type of detachment can ever be determined, and this can be performed only by proper computer analysis of a large number of patients. Perhaps eventually the surgeon can objectively determine the most advantageous mode of therapy and be relieved of his too infrequent emotional attachment to a given technique which he simply "feels gives him the best results."

Input Method

Another method of input which we have not explored as yet is the so-called "variable-field-length format"³ in which information is typed into coded paragraphs which can be varied in length to contain the necessary information and then relayed to the computer. In such cases the computer may retrieve the entire record, parts of the record, or the analysis of contained data may be carried out.

Another interesting method is the so-called "on-line input," in which information may be communi-

cated directly to the computer and data retrieved immediately therefrom. This is accomplished by means of a console.

In order for the vast amount of information in medical records to become available for computer analysis, further standardization of terminology is needed, especially in regards to the findings on physical examination. Narrative findings are not easily reduced to quantitative terms in many instances. The retrieval and study of the data in the vast number of medical records can be invaluable in evaluating certain pre-operative findings as they relate to the effectiveness of various types of treatment and the final result. For individuals to attempt the analysis of large numbers of variables from hundreds or thousands of medical records usually ends in an analysis of a few records and then the application of statistics to determine the significance of most findings. When large numbers of patients and findings are evaluated, the results attain much more significance.

Summary

1. A method of coding medical records for computer analysis on patients with retinal disease and retinal detachment has been described and discussed.
2. Examples of the use of the computer for study of retinal detachment patient records as regards pre-operative findings and results of treatment has been shown.
3. Some of the problems involved in such an endeavor have been discussed.
4. The computer can enable one to retrieve data from large numbers of records and immediate analysis of this data can be carried out, thus saving countless hours for the researchers.

REFERENCES

1. Spencer, W. A. and Vallbona, C.: Application of computer in clinical practice; *JAMA* 191:917-921 (March) 1965.
2. Jenkins, D. R.: Problems of computer applications in medical research; *Trans. N. Y. Acad. Sci.* 28:439-447 (Jan.) 1966.
3. Korein, J.; Tick, L. J.; Woodberry, M. W.; Cady, L. D.; Goodgold, A. L. and Rondt, C. T.: Computer processing of medical data by variable-field-length format; *JAMA* 186:132-138, 1963.

Every great advance in science has issued from a new audacity of imagination.

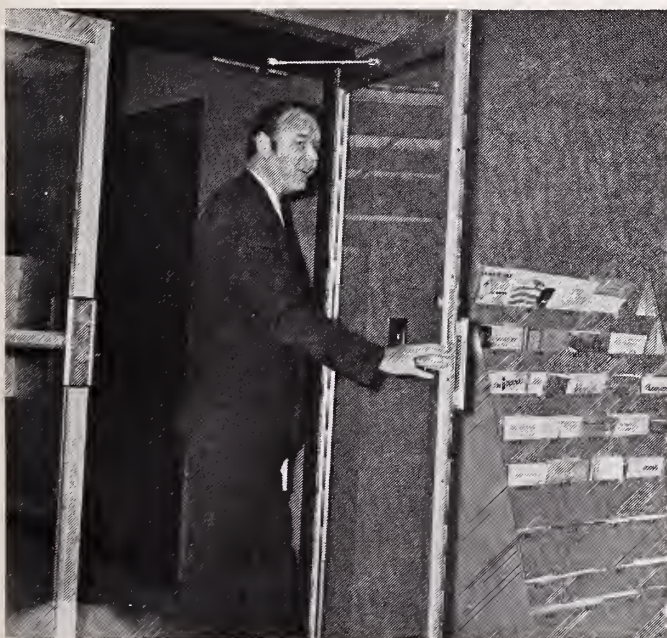
—John Dewey

Inside MAG Headquarters

PATRICIA A. THIGPEN, *Atlanta*

THE NEW ADDITION to MAG Headquarters gives it a new outward appearance, and it is apparent to all who drive by that something has changed. The greatest change, however, is on the inside.

With the addition of a parking deck at the rear of the building, visitors now enter into a sunlit, glass-paneled lobby, furnished with a comfortable sofa and chairs. The restful color scheme of greens and gold encourages one to pause and perhaps browse through medical periodicals on the display racks.



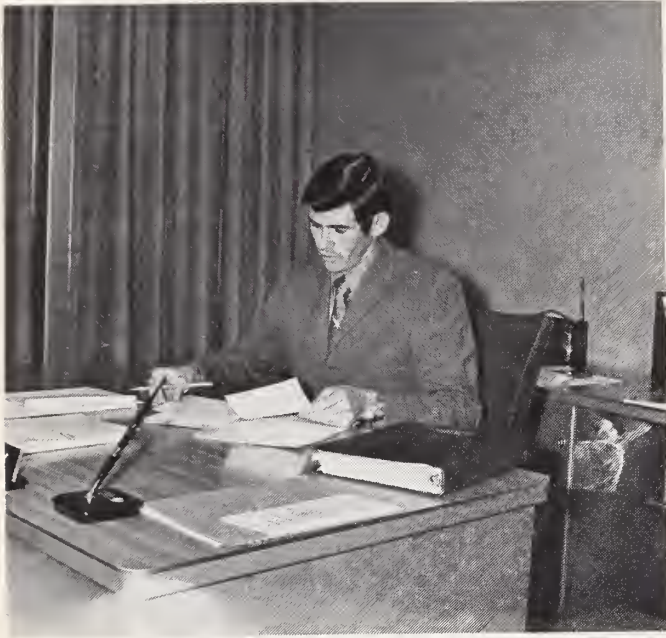
The display racks, however, flank the doors into the MAG office area, and visitors frequently find themselves ushered in by Executive Director Edwin F. Smith, who welcomes every opportunity to assist members.

The glass-fronted staff offices are placed around an open secretarial area, creating a bright and airy atmosphere. Each secretary is placed near her work supervisor, so that communication, instructions, questions and answers are more easily and efficiently handled.



The offices themselves vary in size. James Moffett, Associate Director, has a large amount of space in which to spread out his papers and materials. He is frequently on the telephone, planning meetings, discussing legislative matters, and handling problems of individual members.





Carl Bailey, Field Representative, is frequently on the road, and therefore has a smaller but comfortable office in which to write his travel reports, plan future trips, and coordinate committee meetings.



Mrs. Catherine Wooten, Assistant Director, has made her office into a little bit of home. A modern lamp and a graceful painting give her a pleasant atmosphere in which to work with the Woman's Auxiliary, plan agendas for Council meetings, and handle the myriad of details involved in a truly successful Annual Session.



The President's Office and Executive Director's office are in one long, dark-paneled room, which can be separated by a sliding partition. Mr. Smith's curtains, desk and bookshelves present a most impressive appearance, one in which MAG members can take pride.



The "workroom," which houses the Xerox machine, postage meter, addressograph and supplies, is enclosed in a corner of the building. Ample working space is provided, and the shelf arrangement enables needed supplies to be located at a glance.

The upstairs area, formerly used by the Georgia Regional Medical Program, has been taken over by the CHAMPUS program. Mrs. Joyce Butler, ad-

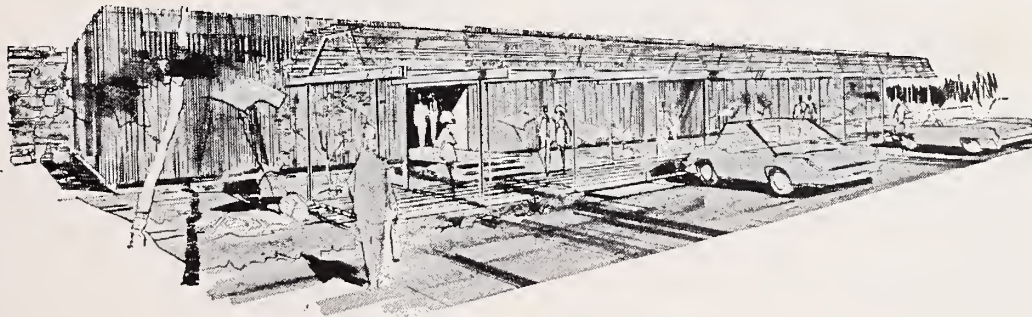


ministrator, now has her own office. Each claims adjuster and secretary now has her own partitioned area in which to talk with participants in the Military Medicare program, type, and fill out forms. The added wall space has also allowed for a more effi-

cient arrangement of filing cabinets.

Pictures may be worth thousands of words, but seeing is definitely believing. We of the MAG Headquarters staff would like to urge you to drop in and see how we've changed.

938 Peachtree Street, N.E.



Metropolitan Psychiatric Center

This beautifully designed 35 bed Hospital centrally located in Atlanta provides modern facilities for the treatment of Psychiatric illness and problems of addiction. Treatment modalities available include psychotherapy, electroconvulsive therapy, Indoklon convulsive therapy, sub-coma insulin therapy, chemotherapy, occupational therapy and recreational activities.

Complete Hospital facilities available including X-ray, laboratory, and treatment room for minor surgical procedures. Consulting medical staff available for treatment of adjunctive medical problems.

Certified for Medicare

METROPOLITAN PSYCHIATRIC CENTER

(Formerly Northside Manor Hospital)

811 Juniper St., N.E. / Telephone 873-6151(404) / Atlanta, Ga. 30308

Member of

American Hospital Association
Georgia Hospital Association
National Association of Private
Psychiatric Hospitals

This paper enumerates recommended methods for using anti-cancer drugs in certain neoplasms. These regimens have generally proved worthwhile in the hands of the authors.

A Cookbook of Anti-Cancer Chemotherapy for Solid Tumors

EDGAR D. GRADY, M.D., THOMAS R. NOLAN, M.D., and
A. J. CRUMBLY, M.D., Atlanta

ROUTINES FOR TREATING CANCERS amenable to chemotherapy are what many physicians tell us they are needing. Through clinical trial and error of our own, our laboratory investigation with tumor bearing animals and by personal contact with and published reports of other workers in the field we have settled (at least for the present) on some definite ways to treat cancers with drugs. One of us has this fall (1969) discussed this methodology at staff conferences at Georgia Baptist, Crawford W. Long and Piedmont Hospitals of Atlanta, and, by request, have written down this "cookbook." Like any other "cookbook," it is subject to the cook's interpretations and variations.

There follows a list of recommended methods for using anti-cancer drugs in certain neoplasms, which have generally proved worthwhile.

CHORIO-CARCINOMA^{18, 3}

Sequential *methotrexate* and *actinomycin D* gives over 70 per cent complete remission. Thirty patients have been documented free of disease for over five years (apparently cured).

Follow urine gonadotropin to evaluate.

If a patient with a hydatiform mole has an elevated gonadotropin excretion, treat her.

Treatment:

Methotrexate 15-25 mg. by mouth or intramuscularly for five consecutive days; repeat the course at two to three week intervals until drug resistance develops or until all disease disappears.

For persistent disease add *actinomycin D*, 0.5 mg. daily intravenously for five consecutive days. Repeat five day courses every two to three weeks.

Another choice is to alternate the two every two to three weeks from the beginning.

WILMS' TUMOR^{18, 12}

When *actinomycin D* is used with surgery followed by external radiation, two year survival rated 89 per cent, compared to 40 per cent for surgery and radiation alone. (Those who last two years are usually cured.) Where lung metastases are present *actinomycin D* plus lung irradiation has given 58 per cent apparent cures. *Vincristine* has also helped metastatic disease. *Cytosan* has helped in some resistant cases.

Treatment:

Diagnosis is usually confirmed by intravenous pyelogram and inferior vena cavagram and clinical impression. (Use one injection of dye for both diagnostic procedures.) Rarely other diagnostic special procedures are needed. *Begin combined attack as soon as diagnosis is made.*

Begin *actinomycin D*, 10 micrograms per kilogram intravenously a few hours before surgery. Continue for 10 days, giving the same dose daily. Via transperitoneal approach, ligate the vascular pedicle first, excise the kidney gently and widely, removing all enlarged nodes, removing any tumor plug in renal vein and explore the other kidney, opening the retroperitoneal space.

Radio therapy is initiated on the day of surgery or the next day or two, giving 3,000 rads at 1,000 rads per week to tumor bed.

NEUROBLASTOMA^{18, 4, 21}

This is usually in children under five, arising in the adrenal or sympathetic nerve chain, most often retroperitoneally. It commonly spreads to bone and has the characteristic radiographic features. This plus urine catecholamine elevated make the diagnosis.

Treatment:

For resectable tumors, where gross removal of tumor is obtained, the tumor bed is irradiated with concomitant chemotherapy. Chemotherapy consists of *vincristine sulfate*, 0.05 mg. per kilogram *intravenously* every other week and *cyclophosphamide*, 10 mg. per kilogram *intravenously* on alternate weeks. Decrease or interrupt drugs when signs of toxicity are present. Continue therapy for 12 weeks or longer if tolerated.

Where gross disease is left behind after surgery or where a mass is non-resectable, irradiate concomitantly with chemotherapy and maintain chemotherapy indefinitely. Consider a second operation.

For remote metastatic tumor, chemotherapy is used alone for long term maintenance. In children under one year, complete remission 50 per cent (three of six) has been reported.

**EMBRYONAL
RHABDOMYOSARCOMA**^{18, 11, 22}

This is a children's disease, most often in the head and neck, frequently in the orbits, usually in children under 12 years. It is responsive to *actinomycin D* and *vincristine*.

Treatment:

Vincristine sulfate intravenously 0.05 mg. per kilogram every other week and *actinomycin D* in the alternate weeks at 10 micrograms per kilogram *intravenously* daily times four. If after six weeks, the tumor is operable, excise it; if not, add external radiation. After this, consider excising the residual four to six weeks after completing radiation. *Cytos-an* has been also reported of benefit and may be an adjunct for resistant disease or may be used concomitantly with the above.

RETINOBLASTOMA¹⁸

Congenital disease found in children under four years. One-third of cases involve both eyes. One-half patients have disease controlled and eyesight preserved using alkylating agents with external radiation.

Treatment:

Cytos-an, 10 mg. per kilogram per week *intravenously*, during and after radiation therapy, until all disease is controlled.

TESTICULAR CANCER^{18, 15}
SEMINOMA

Treatment:

Primary lesion is treated by surgery and radia-

tion therapy. If there is recurrence after the above, use *chlorambucil*, 10 mg. *by mouth* daily for one month. If all metastases diminish, repeat every second month until cancer is eliminated. Thereafter give courses every two or three months for at least two years.

**EMBRYONAL-CELL CARCINOMA,
TERATOCARCINOMA AND
CHORIO-CARCINOMA**

Primary Treatment:

Orchiectomy and transabdominal lymphadenectomy. For residual or recurrent disease:

Actinomycin D, 1.0 mg., *intravenously* daily for four or five days. If all metastases decrease in size, repeat monthly until lesions are eliminated and for two more months. Repeat every two months for six months and then every three months for two years.

HODGKIN'S DISEASE

Fifty per cent of patients with disease confined to one area or two adjacent areas may be cured by radiation therapy to each area involved plus each adjacent area. Lymphangiogram is used to stage disease.

Stage I. Disease limited to one anatomic region or two contiguous anatomic regions on the same side of the diaphragm.

Stage II. Disease in more than two anatomic regions or in two non-contiguous regions on the same side of the diaphragm.

Stage III. Disease on both sides of the diaphragm, but not extending beyond the involvement of lymph nodes, spleen and/or Waldeyer's ring.

Stage IV. Involvement of bone marrow, lung parenchyma, pleura, liver, bone, skin, kidneys, or GI tract.

All stages are subclassified A or B to indicate absence or presence of systemic symptoms (include only: fever, night sweats and pruritis).

Treatment:^{18, 20}

For stage I, II, and III-A radiation only. For stage III-B and IV or for recurrence after radiation, use combined chemotherapy of *nitrogen mustard*, *vincristine*, *methyl hydrazine*, and *prednisone* as follows:

	Day 1	Day 8	Day 10	Day 14
HN2 ...	6 mg./m ²	Repeat		
VCR ...	1.4 mg./m ²	Repeat		
MHD ...	100 mg./m ² /day	Continue for 14 days		
Pred ...	40 mg./m ² /day	Continue for 14 days (First and fourth courses)		

Repeat every four weeks for six courses. Of 30 patients treated this way, all obtained complete remission and of these the mean duration of remission was 18 months before the needed re-treatment. At that time 18 were still in remission.

RETICULUM CELL SARCOMA^{9, 26}

Contrary to others, we have found all reticulum cell sarcomas to be responsive to treatment as outlined below:

Systemic three drug treatment (5 FU, cytoxan and methotrexate) plus external radiation added sequentially.

Treatment Recommended:

1,000 mg. 5 FU intravenously with syringe for the first dose followed by 500 mg. twice a week. Cytoxan 50 mg. b.i.d., p.o.; methotrexate 2.5 mg. p.o., b.i.d.

Check patient twice a week with white blood count and if not too depressed or if no GI tract toxicity, give 500 mg. of 5 FU. Adjust dose, continue or discontinue cytoxan and methotrexate according to same.

After one month, allow WBC to climb to well above 5,000 and when no other toxicity present, begin external radiation. Continue drugs at low dose (e.g. cytoxan 25 mg. q.o.d., alternating with methotrexate 1.25 mg. q.o.d.), if tolerated, during radiation. Maintain indefinitely on chemotherapy after completion of radiation therapy, checking patient's clinical and hemotological condition less frequently as time goes by. Usually this can gradually be weaned to monthly or bimonthly checks.

If control is not complete, change treatment to intravenous Vincristine in small doses for prolonged periods. It has recently been reported that six of nine patients with far advanced reticulum cell sarcoma, resistant to other forms of treatment, showed gratifying response.

Method for Vincristine

Given initial dosage of no more than 25 micrograms per kilogram, followed by maintenance dose of 5 micrograms per kilogram to 15 micrograms per kilogram weekly or biweekly. Change in deep reflexes may be used as a gauge of early toxicity and to omit a dose.

PLASMA CELL MYELOMA¹⁹

Half the patients with multiple myeloma may have their disease controlled for at least several years using cytoxan or phenylalanine mustard, combined with other supporting treatment and drugs.

Treatment:

Pay attention to hypercalcemia, hyperuricemia and immobilization.

Ambulate. Use analgesics, braces, local radiation therapy plus systemic therapy.

Give: *Allopurinol* 100 mg. two to three times per day for hyperuricemia. *Sodium fluoride* tablets and *Prednisolone* are often needed. When symptoms are severe, or when calcium is elevated, or when other treatment is losing control, add Prednisolone 10 mg. q.i.d. and gradually decrease dose to prevent any steroid toxicity. Also support with a combination of androgen and estrogen, e.g. *Halodrin* 1 tablet b.i.d.

Cytotoxic Drug:

A. *Cytosan* 50 mg. p.o., t.i.d., decreasing dose as needed for toxicity. Check WBC two times per week until stabilized and then one time per week and at least monthly or bimonthly. Enforce adequate fluid intake to prevent cystitis from cytoxan. Second choice is:

B. *Phenylalanine mustard*. Give 2 mg. p.o., t.i.d. Check platelet and WBC counts as above and decrease or discontinue drug accordingly.

RENAL CELL CARCINOMA⁵

Treat with pre-op radiation and radical surgery with local node dissection.

Progesterone has given 15 per cent objective response in recurrent or metastatic disease.

Cytosan and 5 FU each have given some help.

Treatment for recurrent or metastatic disease:

1. *Progesterone: Delalutin*, 1,000 mg. intramuscularly five days per week for two weeks and then two times per week or *Depo-provera* 200 mg. intramuscularly five days per week for two weeks and then two times a week.

2. Combine 5 FU, cytoxan and methotrexate as described under reticulum cell sarcoma.

Add additional external radiation to localized lesions where possible after four weeks of chemotherapy and when there is no chemo toxicity.

TRANSITIONAL CELL CARCINOMA OF THE BLADDER, NOT SUITED FOR OPERATION^{24, 6, 13, 9}

1. Recurrent superficial mucosal neoplasms (*topical thio-TEPA*). Dehydrate patient 12 hours (NPO after bedtime) to permit maintenance of an adequate drug concentration.

Dissolve 60 mg. of *thio-TEPA* in 60 cc. of sterile distilled water. Instill it in bladder and leave it for two hours. Repeat once a week for four weeks. Two

weeks later evaluate by cystoscopy. If any effect, repeat, decreasing dose to 30 mg. and increasing intervals to two weeks. When local symptoms subside, cystoscope and fulgurate residue. Check WBC before each treatment and withhold when the WBC is below 3,000. For prophylactic therapy after removal of tumor, begin 7-10 days after bladder is cleaned of tumors by endoscopy or at open surgery. Similarly instill 30-60 mg. of *thio-TEPA* and 60 cc. of distilled water at one to two week intervals for four instillations and then every four to six weeks for a year. Verify tolerance always by WBC before treatment.

2. Invasive and metastatic bladder cancer not suited for cystectomy.

A. Local arterial 5 FU for one to three weeks, followed by external radiation therapy.

Cannulate the internal iliac arteries by selective catheters passed percutaneously through femoral, placed directly at surgery or placed via gluteal arteries exposed through skin incisions. In the latter case, using local anesthesia make a transverse incision just below the mid-portion of a line drawn between trochanter of femur and posterior iliac spine, separate fibers of gluteus maximus and identify for cannulation of the superior or inferior gluteal artery above or below the piriformis muscle. The catheter may (less effectively) be placed in the terminal aorta via a percutaneous femoral artery puncture (Seldinger approach). Infusion is with 5 to 10 mg. of 5 FU per kilogram of body weight per day. After local reaction is all gone and before the tumor cell regrowth begins (two to four weeks after the completion of infusion), external radiation is added, using about $\frac{2}{3}$ of the usual full therapeutic dose and thus decreasing the complications of radiation therapy.

B. Systemic therapy with 5 FU, *cytoxan* and *methotrexate*, as described for reticulum cell sarcoma and again followed by external radiation in the same fashion.

ENDOMETRIAL CARCINOMA^{13, 16}

Initial treatment is well established as radiation and surgery with a 75 per cent to 80 per cent cure rate. If recurrence develops in the vagina, local radiation with radium or seeds may be adequate. For uncontrolled recurrence in pelvis, *pelvic infusion* is recommended as described for bladder cancer, using 5 FU in catheter in terminal aorta, in both gluteals or in both hypergastric arteries. Infusion is not advisable if a full tolerance of radiation has already been given, for its benefit is only prolonged if its regressive effect is followed by external radiation.

In some cases, *systemic* chemotherapy of 5 FU, *cytoxan* and *methotrexate* (as for reticulum cell sarcoma) has produced palliation. Again, when feasible, additional external radiation would be added after four to six weeks of this routine.

All cases of uncontrolled endometrial carcinoma are also treated with *progesterone*—the same dose as described for use in renal cell carcinoma—15 per cent or more have shown improvement with *progesterone* alone.

CARCINOMA OF OVARY^{1, 2, 10, 23}

Combining surgery, external radiation and chemotherapy gives effective control for prolonged periods in many cases of advanced disease.

For Pseudomucinous, Papillary Serous, or Solid Adenocarcinoma the Following Treatment Is Recommended:

Stage I. Tumor limited to ovary with no evidence of breakthrough capsule. Total abdominal hysterectomy and bilateral salpingo-oophorectomy and omentectomy. Follow with strip technique of total abdominal irradiation (protecting kidneys), giving 2,500 to 3,000 rads of cobalt 60. If the patient is young and desires children, only involved ovary is removed and no radiation is given—recognizing that this will give 75 per cent cure rate.

Stage II. Tumor showing breakthrough capsule and extension to other pelvic organs.

Same treatment, but at end of surgery instill 10-30 mg. (usually 20) *nitrogen mustard* into *peritoneal cavity*. When patient has recovered function of her GI tract, begin systemic chemotherapy of 5 FU, *cytoxan* and *methotrexate* as described for reticulum cell sarcoma above. Continue chemotherapy for a month. When patient is fully recovered from the chemotherapy and surgery give full course of external radiation as in Stage I.

Stage III. Abdominal spread outside pelvis.

This is handled exactly like Stage II, except that at time of surgery all resectable gross disease is removed, including any resectable organs needed to get gross disease. Often a large tumor mass will involve omentum, sigmoid and ileum. The uterus, ovaries, tubes and such a mass may be removed *en bloc*. Under some circumstances initial operation will be only to establish extent of the disease and type by biopsy, and to evacuate fluid. In this case, *intraperitoneal nitrogen mustard* (or 15-45 mg. *thio-TEPA*) may be used first to control fluids. Now systemic 5 FU, *cytoxan* and *methotrexate* are instituted as above and continued from four to six weeks. External radiation to abdomen and pelvis, giving only 1,500 to 2,000 rads may now be sufficient to make reoperation entirely feasible. When the pa-

tient's condition is returned to maximum recovery, reoperate, removing residual gross disease, repeating local and systemic chemotherapy much more cautiously and finally adding another 1,000 rads of external radiation to abdominal pelvis if possible in one to three months. Chemotherapy would be maintained in low dose indefinitely.

Stage IV. Metastatic disease outside the abdomen.

Begin treatment with palliative chemotherapy locally and systematically as above. External radiation may be added to localized lesions, and to abdomen if patient responds to chemotherapy. If controlled, laparotomy may be indicated to remove gross abdominal and primary pelvic masses. Again local and systemic chemotherapy plus external radiation would be added as and if indicated by partial response and general condition.

An alternative drug routine has been widely used at M. D. Anderson Hospital in all of above cases and may be tried when above fails or as a first method. *Phenylalanine mustard* (L. sarcolysin) 1.0 mg. per kilogram in 500 cc. of glucose (iced) is given *intravenously* during an eight hour period once every three weeks provided WBC is over 3,000 and platelet count is over 150,000. For depressed counts, drug is withheld until count comes up. Alternatively the drug is given *orally* for dose of 1.0 mg. per kilogram divided over a five day period about every four weeks, again regulating dose with clinical response and WBC and platelet counts. In figuring doses, use ideal weight in obese patients. The general approach to surgery, radiation and chemotherapy is the same at M. D. Anderson, as outlined above.

The following special ovarian tumors usually do not fit into the behavior pattern of the previous ovarian cancers described above and warrant individual consideration:

A. Feminizing mesenchymos (granulosa cell tumors, thecomas and mixtures of these two). Treatment is primarily surgical. Radiation therapy may be added if disease is not totally removed. Chemotherapy is also added as in other ovarian cancers, but has not shown the same success.

B. Arrhenoblastoma (usually masculinizing and with an increase in 17-ketosteroids, or at least in the virulizing fractions seen by fractional chromatography of ketosteroids). Treatment may be limited to excision of the involved ovary, when the patient is young and disease is apparently confined there. If disease has spread, extensive surgery, chemotherapy and irradiation are used, as described for common ovarian cancer.

C. Dysgerminoma. This is similar to a seminoma

histologically and clinically in its response to treatment. Therefore, treatment is usually successful when applied as surgery plus appropriate radiation therapy.

D. Terato Carcinoma. Again, we treat this like a terato carcinoma of the testicle, e.g., surgery plus *actinomycin D* as described under terato-carcinoma of the testicle.

CANCER OF THE CERVIX

Chemotherapy has two places for consideration in cancer of the cervix.

1. In patients who have extensive pelvic disease, and in whom an effort is needed to improve cure rate by additive procedure; e.g. State III-B or IV-A. Here systemic chemotherapy, or local arterial infusion chemotherapy, either one, followed by external radiation therapy, promises to improve the likelihood of disease control. Infusion chemotherapy of 5 FU is done as described under therapy of bladder cancer.

2. Where there are distant metastases or where there is local pelvic recurrence after radiation or after radical surgery, systemic chemotherapy offers about 25 per cent of cases additional palliation. Systemic chemotherapy is with *cytoxan*, *methotrexate* and 5 FU. When radiation is to be added, WBC and hemoglobin are restored to normal before beginning radiation and during radiation therapy patients are maintained on low doses of *cytoxan* and *methotrexate* (e.g. 25 mg. q.i.d. of *cytoxan* and 1.25 mg. q.i.d. of *methotrexate*, according to tolerance).

SQUAMOUS CELL CANCER OF THE VULVA OR ANUS WOULD FIT THE SAME ROUTINE OF CHEMOTHERAPY WITH SIMILAR APPLICATIONS

SQUAMOUS CELL CARCINOMA OF HEAD AND NECK

Wherever extensive disease seems to offer a poor opportunity for cure by conventional surgery or radiation and when the circulation is intact *infusion* with 5 FU, followed by external radiation when local reaction is gone, offers a good chance of cure. In this case, because the volume of tissue is smaller than an area such as the pelvic, the dose is 1-5 mg. per kilogram of body weight per day, according to the volume of tissue being infused. *Systemic chemotherapy with 5 FU, cytoxan and methotrexate* offers an alternative method. If the therapeutic radiation has been given to full therapeutic dose, and recurrence or residual disease is present, infusion is not likely to be well tolerated or as effective, and the only thing possible is systemic drug therapy.

BRAIN TUMOR²⁵ (Primary or Metastatic)

Two methods of treatment with anti-cancer drugs are to be considered, according to the conditions of the patient and to the location of the tumor. For metastatic disease, an effective therapy may be *arterial infusion* with a catheter in the internal carotid artery using *Velban* for 1-2 mg. per day, for one to three weeks. This is followed in another one to three weeks by external radiation therapy.

For primary central nervous system tumors, especially medulloblastoma or malignant ependymoma, *intrathecal methotrexate* has provided long term control of disease. This is especially applied when a shunt with a subcutaneous reservoir has been made, for easy chemo access. Routinely, punctures are made in the reservoir and lumbar subarachnoid space, dividing the medicine between the two places. 0.25 mg. to 0.375 mg. of methotrexate per kilogram are given two to 14 days. The more frequent injections are covered with equal doses of *citravorum factor* given intramuscularly.

BREAST CANCER^{7, 8, 17, 23}

There is a real use for anti-cancer drugs here. Adjunct chemotherapy, during and after mastectomy, has many advocates. The national study showed that 0.8 mg. per kilogram of *thio-TEPA* increased significantly the survival of premenopausal patients with positive axillary nodes. It has been urged at many symposia and meetings the "prophylactic" systemic chemotherapy be extended for many months. *Wound irrigation* with *nitrogen mustard* has been established as the best tolerable agent for washing out tumor cells implanted in animal wounds, and many surgeons find this a good solution for decreasing local recurrence in breast cancer wounds. Combining three anti-cancer drugs with appropriate hormones has proved in several centers to be 90 per cent effective help in metastatic breast cancer.

Treatment Routines:

At time of initial surgery:

1. Irrigate wound with 2 mg. of *nitrogen mustard* per 100 cc. of saline (10 mg. in 500 cc. of normal saline) for five minutes (mix the drug only when ready to use, as it has about eight minutes of usefulness after mixing). Mop the wound dry with a pad. Apply both a pressure dressing with mechanics waste and ace bandages and use suction drainage—as nitrogen mustard does increase tendency to give fluid formation (satisfactorily controlled by these methods).

2. Give *intravenous thio-TEPA* 0.4 mg. per kilogram during surgery. Give another .2 mg. per kilo-

gram on the first and second postoperative day. If axillary nodes are positive, in the postoperative phase, continue *intramuscular thio-TEPA* 7.5-15 mg. per week as needed to keep WBC below 5,000 for six months.

If metastatic carcinoma develops, the treatment will be modified considerably according to its location and extent and according to the condition and age of the patient.

When the ovaries are still functioning, all agree the first step is oophorectomy. For minimal disease, this may be done alone, to evaluate its effect. For extensive disease or for persistent disease after oophorectomy or for the postmenopausal patient, the following routine is recommended:

Cytosan, *methotrexate*, 5 FU, as described above for reticulum cell sarcoma. In addition, an anabolic agent (e.g. *dianabol* 5 mg. b.i.d.) and therapeutic steroid dose are given (*prednisolone* 10 mg. q.i.d.). The anti-cancer drugs and anabolic agent are continued at a subtoxic level indefinitely. Steroids are reduced to prevent Cushing's appearance. The patient is usually in the hospital for a week to regulate her medicine and evaluate her response, and then is seen as an out patient twice a week for a month. Visits are gradually spaced more widely up to once a month if disease becomes well controlled. Drugs are regulated according to WBC and symptoms.

Velban has been found an effective drug to be substituted or added, according to need of help. When the blood calcium is elevated, corticosteroids are life saving and must be used.

Local lesions may be helped by external radiation, of course, either alone if there is only a local lesion like a skin implant, or in conjunction with other therapy, as in a collapsing vertebra, when there is generalized bony disease.

In the postmenopausal patients for minor disease, it may be appropriate to try *estrogen* and *progesterone* together for its evaluation. *Stilbestrol* 5 mg. t.i.d., is the appropriate dose for the former and progesterone as described under treatment for renal cell carcinoma. *Stilbestrol* alone gives 27 per cent remissions. *Stilbestrol* and progesterone give 41 per cent remissions.

CANCER OF THE COLON, RESIDUAL OR METASTATIC

Here the best treatment is with the same three drugs of 5 FU, *cytosan* and *methotrexate* as described above. Treatment would continue indefinitely. Ascites from peritoneal implant is treated by *intraperitoneal nitrogen mustard*, 10-30 mg., p.r.n. In instituting treatment, this is usually done first, withdrawing all fluid possible to enable palpation of disease for its evaluation. When reaction has

subsided 24-48 hours), the other drugs are added. *Mustard* is repeated as needed for re-accumulation of fluid. If there are localized masses, external radiation is added after four to six weeks of chemotherapy and again after WBC and hemoglobin are near normal range prior to adding the radiation. If the disease is localized to the liver, we have usually treated the liver with *hepatic artery infusion* of 5 FU (500 mg. per day), for two to four weeks, followed by internal radiation of 90-Y radioisotopes. We are investigating *intraperitoneal* and *intra-arterial colloid 32-phosphorus* for this same purpose. External radiation may be of value to the liver after systemic or local chemotherapy.

At time of colectomy, if metastasis is present in the liver, this is the time to cannulate the *hepatic artery* for 5 FU and *isotopes infusion*. We are also investigating the use of radioisotopes to treat liver prophylactically in cases where there is no visible liver disease, but there is a high probability of its occurring later (e.g. where there are positive nodes and breakthrough colon serosa with tumor and venous invasion).

At the present time, we can recommend in such a case that the patient receive, at least, *prophylactic chemotherapy* of 1,000 mg. 5 FU per week for six months, the dose again being adjusted according to the WBC and the toxic reaction.

CANCER OF THE STOMACH, GALLBLADDER AND PANCREAS

These have proved resistant to palliative chemotherapy. Still, in certain cases, it may be worth trying 5 FU, *cytoxan* and *methotrexate* together followed by external radiation. There is significant help in 25 per cent of the cases.

LUNG

For squamous cell carcinoma of the lung use the same routine as above with the same expectations. For adenocarcinoma of the lung, use *Velban* 7.5-15 mg. per week with *cytoxan* 25-100 mg. per day with about the same expectations.

SKIN¹⁴

One per cent 5 FU in *propylene glycol* applied with finger b.i.d. for three weeks is very effective in actinic keratoses.

Five to 20 per cent 5 FU in aquafor cream applied once daily for six to 16 weeks has shown effective eradication of some small basal and squamous cell carcinomas.

Here is one special rule of warning to be observed by all who use toxic drugs:

When in doubt about a toxic reaction, do not give toxic drugs, because you can always give them a little later.

If the patient seems to be getting significant toxicity of the gastrointestinal tract or bone marrow, or if there is a definite trend toward such (e.g., WBC dropping from 12,000 to 8,000 to 5,000) stop the drugs until the maximum change occurs. When conditions are verified to be good enough, resume drugs cautiously. We do not need clinical toxicity to achieve a therapeutic result.

2736 Felton Drive—Suite G

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REPORT ON CONGRESS ON MEDICAL EDUCATION

The Annual Congress on Medical Education presented by the Council on Medical Education of the American Medical Association is becoming a real potpourri of programs associated in some fashion with education of health personnel. Held in Chicago, this year the program began on February 5, and concluded on February 9. Included in the earlier programs were meetings of the Association for Hospital Medical Education, the Federation of State Medical Boards of the United States, the Student American Medical Association, and the Society of Teachers of Family Medicine.

The official program of the Council on Medical Education began on Sunday morning, February 8, 1970, and ended late Monday afternoon, February 9. The program was divided into four sections, each with its own battery of speakers and panels. As usual, some of the top men in the nation were obtained to discuss the various aspects of the subjects at hand. The following represent some of my thoughts concerning these presentations.

The first division was entitled "Medical Education for Medical Practice." Medical educators, medical students, allied health educators, allied health students, and practitioners made up the discussion group for this topic. One theme that recurred was that medical education presently is not relevant to medical practice. It was felt by several speakers that learning how to deal with patients is a different educational experience from, and un-related to, learning the basic health sciences themselves. It was expressed that much more emphasis on sociological and behavioral attributes of physicians, and the teaching of these principles, should occupy the medical curriculum of the future. Allied health professional and medical students should be educated together, so that each would be able to learn how to work with the other. Another recurring theme, harkening back to some by-gone days, was that practicing physicians have much to offer in the educational process of medical students, and may be able to teach some of the skills necessary in dealing with patients considerably better than professional educators who have not been involved in the actual practice of medicine.

Accreditation

The second portion of the program concerned itself with Accreditation and the Public Interest. Dr. Frank Dickey, Executive Director of the National Commission on Accrediting, led off these discussions with his

paper entitled "The Social Value of Professional Accreditation." It became apparent readily that the voluntary accreditation process inherent to America must re-examine its goals and responsibilities if it intends to remain voluntary, and not under the yoke of some governmental body. If the accreditation process of institutions and programs cannot be explained logically to the public to which these bodies are accountable, then Congress may take over some of the direction and control of these accreditation processes. Some thought was given to the possibility of accrediting medical education in a larger sense: i.e., accrediting both undergraduate medical education and graduate medical education in a single package.

How to maintain standards, while continuing to expand physician production, was discussed at some length. Several mentioned that new educational technological advances might be able to accomplish this. Accreditation problems are multiplied by the allied health professions and programs emerging today. Again, some form of wide-ranging accreditation of entire institutions was expressed as being one way of handling this kind of problem.

The third topic was entitled "Recognition of Professional Competence" and dealt with such subjects as "the significance of the M.D. Degree," "Specialty Board Certification as a Measure of Professional Competence," and "The Maintenance of Competence: Voluntary or Compulsory?" It was stated that medical school curricula are changing and will continue to do so, not simply by re-arrangement of existing patterns or courses, but by an entire remodeling of types of courses and time sequencing within the curriculum.

One noted medical educator felt that universal certification by specialty boards probably would become a necessary prerequisite for the future practice of medicine.

Changing Curricula

One interesting comment concerns the Atlanta area indirectly. Because of the changing curricula, it is possible that two-year medical schools may have to phase-out or become M.D. Degree granting institutions. One of the major ways of curriculum change in effect today is to shorten the medical education process to three calendar years. (Thirteen medical institutions in the U.S. today are granting M.D. Degrees in three years, or are in the process of establishing such a cur-

riculum.) Thus, a two-year medical school graduate would be unable to phase into such a program easily.

Another recurring theme concerning certification was the problem of re-certification, and many voiced the opinion that just as certification may become a prerequisite to the initial practicing of medicine, so re-certification seems destined to become requisite to the continued practice of medicine.

More comments on accreditation were brought out in this portion of the program, and it was voiced that accreditation of continuing education programs in local hospitals, county medical societies, etc., may become advisable, or perhaps even a necessity. Logically, it would seem that this might become a function of the Medical Association of Georgia within our State boundaries.

The last portion discussed Employment Relationships of Students in Health Professions. The most pertinent comments for Georgia in this group of presentations seem to be related to externships. Dr. Porterfield, Director of the Joint Commission on Accreditation of Hospitals, states that the Deans of the medical

schools should approve hospitals which wish to offer externships to medical students. If this is accomplished, then the accreditation of the hospital will not be in jeopardy. Dr. Porterfield added should the Deans prove unwilling or unable to approve such relationships, then some other quasi-official body, perhaps such as the Medical Association of Georgia, should take that responsibility. It would seem from past experience that the medical schools will not be able to assume the responsibility for approving all externships throughout the State. Thus, the Medical Association of Georgia might well be utilized in some fashion in doing so. Whoever certifies that any given hospital is competent in its educational activities to become approved, the Student American Medical Association must be involved in making these decisions.

As usual, these programs were stimulating and challenging, and very much worthwhile for members of the Medical Education Committee and the Allied Health Committee to attend. Change is occurring rapidly in health education throughout the nation, and it is important for our Association to be on top of them.

J. Rhodes Haverty, M.D.

PATHOLOGISTS WEIGH CORONER SYSTEM VS. MEDICAL EXAMINER SYSTEM

Has the time come for Georgia to abandon the coroner system and install the medical examiner system in its place? This was the theme of a recent two day meeting of the Georgia Association of Pathologists in Atlanta.

The Pathologists heard the issue discussed from all sides; legal, medical, practical and financial, and the consensus conclusion seemed to be that the time has indeed come for the State-wide implementation of the medical examiner system.

Speakers on the program included Dr. W. U. Spitz, M.D., Deputy Chief Medical Examiner for the State

of Maryland. Dr. Spitz is an Associate Professor of Forensic Pathology at Johns Hopkins University and the University of Maryland.

In addition to Dr. Spitz, the Pathologists also heard a legal discussion of the matter from Dr. Lindsay Cowan, Dean of the School of Law, University of Georgia. Other participants on the program were: Dr. L. B. Howard, Director, Georgia State Crime Laboratory; Mr. J. W. Stokes, U.S. District Attorney, Atlanta; and Mr. Cullen Ward, an Atlanta trial lawyer. Present as an observer was State Representative Milton Jones of Columbus, Georgia.

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A plea is made for drug administration only when clearly indicated and constant alertness for untoward reactions.

Unusual Reactions to Common Cardiovascular Drugs

CHARLES E. HARRISON, JR., M.D. *and*

NICHOLAS E. DAVIES, M.D., *Atlanta*

"... the desire to take medicine is one feature which distinguishes man, the animal, from his fellow creatures. It is really one of the most serious difficulties with which we have to contend. Even in minor ailments, which would yield to dieting or simple home remedies, the doctor's visit is not thought to be complete without the prescription." Osler¹⁶

AT THE TURN OF THIS CENTURY, it has been estimated that a patient had a 50-50 chance of profiting from a visit with a physician. During the first half of the twentieth century there was considerable improvement in these odds, and much of the improvement was due to the development of therapeutic agents. This era might properly be called the "therapeutic revolution," for during this time a number of diseases were virtually eliminated, and many others came under varying degrees of medical control. New drugs increased exponentially, and many of these drugs were found to be vastly better than their older counterparts.

During the past 10 years it has become apparent that the results of the remarkable advances in therapeutics have not always been salubrious: some therapeutic agents initiate disease processes. These processes are sometimes "new" diseases, and others are familiar pathologic states with perhaps slightly different clinical courses. These have become known as "diseases of medical progress."¹²

Most physicians are aware of the common complications of the drugs they use in their daily practices. Problems arise, however, from the use of new drugs whose toxic effects have not been completely defined, and from the uncommon reactions to the older drugs. It is with the latter type of adverse drug reaction that this paper is concerned.

Recently we have had an opportunity to study patients with a variety of reactions to commonly

used cardiovascular drugs, some of which are relatively new and some very old. We feel that these patients' problems warrant brief reports.

Procainamide

A 64-year-old female was admitted to the hospital with a temperature of 103 degrees (F), severe myalgias and arthralgias of three days' duration. For 38 years she had had episodes of paroxysmal atrial tachycardia as well as essential hypertension, and she had been hospitalized at least five times with this arrhythmia. On one occasion she was thought to have had a small myocardial infarction. She had taken quinidine intermittently for many years because it prevented the arrhythmia, but it caused diarrhea. She had used procainamide (Pronestyl) periodically for nine years with only fair control of her tachycardia, and had resumed this drug two months prior to admission. Her present illness began five weeks prior to admission with symptoms of esophagitis thought to be related to a small hiatal hernia. In the hospital she had positive LE preps, a mild anemia, a white blood count of 4,600 with 5 per cent eosinophils, and elevated gamma globulin on serum electrophoresis. Procainamide was stopped on admission and her symptoms abated slowly. Her LE prep is now negative and she has had no more symptoms of systemic lupus erythematosus.

Comment:

Lupus-like reactions to procainamide are either becoming more common or are being recognized more often.^{7, 8} To date, more than 40 cases of this disease have been reported. Undoubtedly this is only a small fraction of the number that have oc-

curred, or that have been recognized. Other drugs known to cause the lupus-like syndrome are hydralazine, diphenylhydantoin, isoniazid, and, rarely, penicillin, phenylbutazone, sulfadiazine, and trimethadione. We suspect that many cases of lupus erythematosus that seem to remit spontaneously, or that are mild when compared to the relentlessly progressive form of the disease, may well be due to one of these drugs. Prospective epidemiologic studies patterned after the work of Siegel and associates¹⁷ in New York will be needed to determine the true incidence of drug-induced lupus-like disease.

Quinidine

A 71-year-old male developed heart failure and atrial fibrillation on the basis of coronary atherosclerotic heart disease. He was digitalized with digoxin, but his rapid ventricular rate was difficult to control. Quinidine was added to the regimen because of ventricular irritability, but there was no improvement. He was hospitalized for monitoring, and all drugs were stopped. Both procainamide and lidocaine were used with only modest success. After a week of digoxin withdrawal the ventricular irritability disappeared. His atrial fibrillation was then successfully cardioverted, and he resumed a normal sinus rhythm. Quinidine was again started, but after two doses he noted gingival bleeding and purpura on the legs. His platelet count was 10,000. The quinidine was stopped. Five days later there was no evidence of fresh hemorrhage, and the platelet count was 250,000.

Comment:

Purpura due to quinidine has been recognized since 1927, but case reports did not begin to appear until after 1940.^{3, 11} It is seen predominantly in females and in the elderly. There is a distinct temporal relationship between ingestion of the drug and the onset of purpura. Generally there have been previous courses of quinidine therapy, as in our patient, but there is no correlation with the amount taken or the continuity of treatment. When the drug is stopped, recovery of the platelet count is generally complete within seven days. Corticosteroids are usually not necessary in therapy. Quinidine acts as a hapten, combining with platelets to form an antigen to which the body produces an antibody. When quinidine is again administered, antibody binds the quinidine-platelet complex, and in the presence of complement produces lysis of the platelets and clinical purpura. There is no cross-reaction with quinine.

A 45-year-old female was seen initially in April, 1963, with menorrhagia due to a uterine fibroid, and her hemoglobin was 12 gms/100 ml. In November, 1963, her blood pressure was 180/110 mm. Hg., and she was started on methyldopa (Aldomet). Following this her hemoglobin ranged between 9 and 10 gms/100 ml., and her hematocrit averaged 30 per cent. She was hospitalized in January, 1966, for hysterectomy, but was unable to be crossmatched for blood because of a panagglutinin. Both direct and indirect Coomb's tests were positive. Serum bilirubin was normal, but reticulocytes were 5.5 per cent. The patient's red blood cells appeared small and hypochromic on smear, and there were no spherocytes present. She was treated for several weeks with corticosteroids, but this was discontinued when there was no change in her blood count. Methyldopa was discontinued in March, 1967, and within a month crossmatching was possible. Hysterectomy was performed. Following this her hemoglobin and hematocrit were normal. The patient has subsequently been well.

Comment:

This patient had a microcytic, hypochromic anemia of moderate degree and concomitantly had a panagglutinin demonstrated in her serum. The latter disappeared after methyldopa was stopped. The exact role of this drug in the production of the anemia is unclear. Reports of immunohemolytic anemia due to methyldopa first appeared in 1965. About 20 per cent of patients taking this drug for more than one year developed a positive direct Coomb's test.^{2, 10} Worledge¹⁸ expects an autoimmune hemolytic anemia to occur in 0.1 to 0.2 per cent of patients taking methyldopa. In most patients the Coomb's test reverts to normal within three to four months after the drug is withdrawn. A positive Coomb's test should alert one to the possibility of hemolysis, but should not be a contraindication to the continued use of methyldopa if the patient is benefiting from its antihypertensive effect.

Digitalis

A 70-year-old male attorney with a long history of moderate hypertension and mild aortic stenosis developed angina upon exertion and paroxysmal atrial fibrillation that usually occurred during sleep. Quinidine caused severe diarrhea, and during procainamide therapy he developed biopsy-proven vasculitis with negative LE preps. A mild Stevens-Johnson syndrome occurred while he was taking

* The authors are grateful to Dr. O. E. Hanes for the opportunity to include this patient in the report.

diphenylhydantoin. He had known allergies to penicillin and sulfa. While on digitalis leaf 0.1 gm. daily, nitrates, and small amounts of quinidine, he developed gynecomastia, first in the right breast and then bilaterally. The breast enlargement and tenderness has persisted for about six months. There is no evidence of liver disease or other causes of gynecomastia.

Comment:

Digitalis-induced gynecomastia was first described by LeWinn in 1953.⁹ Although the condition is fairly well known among internists, it has not been reported very often, perhaps because of the benignity of the process. Clinicians whose practices contain many elderly people on digitalis report that that as many as 10 per cent of the males will develop breast swelling and tenderness after taking the drug for more than a year.⁴ Digitalis is known to cause an estrogenic effect of the vaginal mucosa of post-menopausal women after a period of time.¹³ Undoubtedly it is this same effect, associated with a relative lack of the male hormone in elderly males, that produces gynecomastia.

Comments

It is impossible at this time to estimate the number of adverse drug reactions, either serious or trivial, that occur. There are many reasons for this, the first being the lack of a standard definition of an adverse reaction. Koch-Wesser et al.¹⁶ used what appears to be a practical definition in an excellent study done at the Massachusetts General Hospital. Their definition of an adverse drug reaction was: "Any noxious change in a patient's condition which a physician suspects may be due to a drug, which occurs at dosages normally used in man, and which 1) requires treatment, or 2) indicates decrease or cessation of therapy with the drug, or 3) suggests that future therapy with the drug carries an unusual risk in this patient." This definition omits expected side effects, and it does not consider overdosage from whatever cause it might occur.

Sporadic reports from practicing physicians do not give a true quantitative estimate of adverse drug reactions. Many reactions that are merely inconvenient or uncomfortable are too trivial to report. Other reactions are quite common and do not warrant reporting. Many adverse reactions go unrecognized. In the report by Koch-Wesser and associates it was noted that three new adverse reactions were discovered during the year and one-half that the surveillance study was in progress.

Several excellent studies of adverse drug reactions in hospitals have been reported recently, and these form the basis for current estimates of the

problem. Seidl et al.¹⁶ at the Johns Hopkins Hospital found that of 714 patients studied, 122 had at least one adverse drug reaction; 13.6 per cent of the medical population in the hospital acquired an adverse reaction of some sort while hospitalized. Ogilvie and Ruedy¹⁴ in Montreal found similar figures: 18 per cent of their hospitalized patients had adverse drug reactions. About 5 per cent of hospital inpatients suffer from severe adverse reactions, and about 4 per cent of admissions to a medical service are precipitated by drug reactions.

Reactions Reported

Unusual drug reactions are often first reported by a practicing physician. The reasons for this are at least twofold: 1) while animal studies may help predict the pharmacological properties of drugs, only in man can specific immunologic and idiosyncratic mechanisms be defined;⁵ 2) "only practicing physicians observe a population at risk large enough to display rare reactions to commonly used drugs."⁶

The four patients reported in this paper each had an uncommon reaction to a commonly used cardiovascular medication. Unless a physician is aware of such reactions and is searching for untoward responses to drugs, he can easily overlook them.

Each drug must have a clear indication, and if it is not clearly indicated, it should be considered contraindicated. The physician should know the pharmacodynamics of the drugs he uses, and he must use new drugs with caution. When using a new drug, he must be constantly alert for changes in symptoms, physical findings and laboratory tests that suggest an untoward reaction. We believe that, with certain exceptions, the best physicians are those who use the fewest drugs. Upon seeing an ill patient for the first time, many physicians stop all medications to ascertain where the patient stands in relation to his disease and therapy. This practice might be emulated by all practicing physicians.

"The sicker you are the more drugs you can take without getting sick. That's why doctors don't get into more trouble than they do with therapy."—Stead¹

Four patients with uncommon reactions to frequently used cardiovascular drugs are presented. These include a lupus-like syndrome due to procainamide, thrombocytopenic purpura during quinidine administration, immunohemolytic anemia presumably due to methyldopa, and gynecomastia secondary to digitalis. An adverse drug reaction is defined and frequency is noted in several hospital samples.

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—Sir George W. Pickering

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Major Difficulties in Successful Mental Health Program Development on Community Level

ADDISON M. DUVAL, M.D., *Atlanta*

WHEN I SPEAK TO YOU TODAY concerning successful program development, I am speaking specifically about mental health programs.

In Georgia, the Division of Mental Health of the State Health Department has major responsibility for state-wide program development concerning the treatment and prevention of mental illness, mental retardation, and alcoholism. As a component part of the Department, the Division programs are firmly based on the principles of public health which include primary, secondary and tertiary prevention.

In primary prevention we preclude the development of the disease in the first place. In secondary prevention we treat as early and as successfully as possible. In tertiary prevention we try to avoid the development of scarring or other residuals of the disease process. Here is where we join hands with the rehabilitation specialist for this is also his primary role.

Over the past 20 years it has been my happy lot to assist in an active way in the growth and development of rehabilitation as applied to the mental disorders. This growth of rehabilitation has been truly remarkable and the growth potential is not yet exhausted. Such potential would seem to be limited only by possible shortcomings in conceptualization by the professionals in our two fields.

Successful Relationship

I am happy and proud to tell you that in Georgia we have a most successful and pleasant relationship between the Division of Mental Health and the Di-

Presented at the National Institute on Rehabilitation of the Handicapped, Biloxi, Mississippi, March 1969.

vision of Vocational Rehabilitation. Believe it or not, we have a rehabilitation program in active operation in every one of the mental health programs in the State. These include (1) State hospitals for mentally ill, the mentally retarded and the alcoholic, (2) comprehensive community mental health center programs, and (3) our special research and training institutes.

Rehabilitation programs in each of these operational units have been specifically planned to meet the needs of that particular patient group. In our largest mental hospital we have developed a 360-bed special rehabilitation center with an extensive program of vocational evaluation and training. Some 1200 patients are in active rehabilitation programs. Included in our comprehensive community programs are in-patient, out-patient, part-hospitalization, emergency services, consultation and education services and aftercare. As additional services, rehabilitation has added evaluation, counseling and training and also half-way houses and job counseling after-care services to patients in their homes in all counties in the State.

At the present time we are seriously considering the addition of rehabilitation services to the other basic required services of all new comprehensive mental health center programs. If this occurs, I believe it will be the first such specific requirement in any State of the Nation affecting rehabilitation.

Some Difficulties

Unfortunately, the mutually successful cooperation which has developed between rehabilitation and

mental health has not been duplicated in some other relationship areas and I want to tell you briefly about a few of these difficulties.

One of our problems relates to certain voluntary groups. As the Division of Mental Health has supervision of programs for the prevention and treatment of mental illness, mental retardation and alcoholism, we naturally need to work closely and cooperatively with the State Mental Health Association and its chapters, the State Association for Retarded Children and its chapters and likewise with Alcoholics Anonymous.

Our experience is that each of these groups in the different communities is interested only in its own program area and has no desire to be closely associated with the other two. Such attitudes are deterrents to the development of one coordinated program with its combined multi-disciplinary professional staff which is all the community can afford in most instances. It will take consistent and continuing effort to overcome this problem and we have not solved it yet.

Lack of Coordination

As part and parcel of this lack of coordination and mutual interest in our three categorical programs, we are finding a wide variance in the understanding, motivation and capability of the various communities in our State to move toward the development of comprehensive mental health programs. We expect the same problem in the development of Comprehensive Health Centers. It may be that this variance of motivation and capability will wind up as an asset to program development rather than a liability especially with regard to the necessary funding of these programs. Funding can be less critical and catastrophic if it can be spread over a larger span of years than if required all at once.

Only a few years ago, a number of states established separate state departments of mental health in an effort to give more emphasis and visibility to the expanding mental health effort. Now that the concept of Comprehensive Health Planning is receiving much emphasis and as most often the State Health Department is named as the single State agency responsible for major program development, it is not unusual or unexpected for relationship difficulties to develop between separate public health and mental health agencies. We understand this problem now exists in a number of States.

In Georgia, we experience little of this conflict as we have one big health family operating under policies of one State Board of Health. While we do have a few intra-familial differences these are of a

minor character and easier of solution than the inter-agency difficulties.

Added Complication

Another complication I wish to include in this brief presentation is that of role definition of the professional disciplines necessary for full program development. In the mental health field we have thought of psychiatrists, psychologists, social workers, and nurses as representing the core disciplines. But already other necessary professionals are being added such as sociologists, rehabilitation specialists and clinical chaplains.

In most instances, each of the professional groups are expanding their roles into new and uncharted territory and in so doing are stepping on each other's toes—and getting in each other's way. Naturally, this has produced some degree of anxiety, competition and threat to traditional stability—particularly in the older disciplines. At the present time principal conflicts appear to be between psychiatry and psychology, and between social work and nursing. No doubt other conflicts will arise as the so-called activity therapies—occupational and industrial therapy, music therapy, dance therapy and recreational therapy—find their own expanding roles in the helping process.

This problem of role definition extends not only to the therapeutic arena but also is found in the areas of education, research and rehabilitation. Surely in our scientific search for truth, we need the specific contribution from every helping group. The challenge which faces us is how to encourage each of these groups to continue their growing edges of knowledge and skills without deterrent interdisciplinary conflict. This job can be done and must be done.

State-Federal Relations

The last difficulty, I wish to mention, is in a somewhat different category, namely state-federal relations. For several years I have been critical of the National Institute of Mental Health in particular on several counts. The first was on their assumption that all the community mental health programs in all the states could be developed on a single model which was untested and unproven. In the long view this may prove more a deterrent than a help. In my view it would have been better to let the various states use this model as well as other models, which they would have developed based on their better knowledge of their state communities, with their different unique mores, attitudes, sophistication, and professional and financial capabilities. But a stubborn federal attitude has persisted to the present time which precludes the states

from the use of new creative models, discourages those states which have the courage to break with tradition, and encourages the states to continue inappropriate dependency on the "great federal-father in Washington."

The present restrictive single federal model also suffers from the fact that it requires a community to provide full and adequate delivery of the five essential services from the beginning of the center program. Again, I believe it would have been much more helpful as well as practical for an arrangement where each community could have been permitted to develop its program elements in a gradual sequence—one after the other—to the same completeness but done in accordance with its particular staffing and financial capability. We have been unsuccessful in convincing federal administrators that our position is the better one and we may have to resort to amended federal legislation to settle this issue.

Finally, in recent years there has been much hope for a shift of administrative control from federal level to state level. It would appear to me that unless the states can develop more leadership responsibility in the Comprehensive Health Program—now in progress—we will see in the years ahead even weaker state control and greater federal control. I doubt if the states will have another chance in this century to show realistic competition with the federal establishment if they fail in the present instance.

Summary

In summary, I have tried to point out to you several of the major difficulties in the development of community mental health programs.

All are certainly capable of solution even though some are most complex and difficult.

This is the special challenge of our time and we must not fail.

47 Trinity Avenue

THE MONTH IN WASHINGTON

The Senate Finance Committee approved a staff report on medicare and medicaid which was critical of both physicians and administration of the health care programs. It included a recommendation for fee schedules for physicians' services.

In a joint statement, the presidents of the American Medical Association and the National Medical Association pledged support of their organizations to the committee's efforts to correct deficiencies and abuses in the two programs. However, the two spokesmen for organized medicine said "it would be tragic if . . . regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos."

The AMA-NMA statement said that "we were greatly encouraged by the committee's comment that it believes that the majority of physicians for whom information was requested with respect to medicare and medicaid as presently structured have dealt fairly with these federal programs and with the federal government."

Statement on Abuses

In regard to abuses and fraud, the statement said:

"Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take very vigorous action within their power to help the committee and the government accomplish this."

It was noted that the committee had denied an AMA request many months ago that it be given the names of physicians involved in the committee's investigation.

"Despite this," the statement said, "the AMA and the NMA through their own resources have been able to identify a number of physicians grossing more than \$25,000 in these programs. . . ."

Appropriate Action

"In some instances, medical societies had already taken appropriate action against individual physicians where the evidence warranted. In other instances, however, the AMA and the NMA have found that many of the physicians presumably included in the committee's study are dedicated physicians working in isolation in slum and rural areas who are literally being overwhelmed by a tide of sick humanity. . . ."

"We therefore believe it would be unfortunate if the committee's report leads the public to believe that medicare and medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case. . . ."

The report said that incomplete and partial listings indicated 4,300 individual practitioners plus an additional 900 physician groups each received at least \$25,000 from medicare in 1968, including 68 who received \$100,000 or more. The report also included a long list of physicians by state receiving \$25,000 or more from medicaid in 1968. None was named; listings were by code numbers.

Possible Abuse

"Hundreds of the payments profiles indicate that the physicians involved might be abusing the program," the report said. "For example, we found many general practitioners each paid \$15,000, \$20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes."

The staff believes that the majority of physicians

on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, medicare's payments structure did little to discourage—in fact, it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians.”

Recently, the Social Security Administration reported that about 2,500 cases had been investigated for fraud or abuse during the first three and one-half years of medicare. It was emphasized that this was only a minuscule fraction of total medicare transactions. Social Security Commissioner Robert M. Ball said:

“Medicare pays about 30 million doctors’ bills and 12 million bills from institutional providers of services each year. It is clear from our investigations that the number of attempts at fraud or abuse is relatively very small.”

Errors in Cases

About half of the cases investigated, he said, resulted from clerical errors, misunderstandings or honest mistakes by physicians and health services. To Jan. 20, 1970, the SSA had referred the cases of 13 individuals and organizations to the Justice Department with recommendations for criminal prosecution for fraud. Two physicians have been convicted in U.S. district courts and indictments have been returned against another five physicians and one non-physician. Another five cases had been referred with recommendations that civil proceedings be started for the return of illegally collected funds. Early this year, social security investigators also were preparing an additional 35 possible fraud cases for referral to the Justice Department.

The most common types of alleged violations reported include physicians and providers billing for services not rendered, excessive charges, alteration of bills, duplicate billing, misrepresentation of types of services or dates of services, unreported discounts, or kickbacks, and employee embezzlement, medicare officials said.

The report's recommendations were aimed at providing “bases for remedying the serious, costly, and pervasive problems” of the two programs and make them “work more efficiently and economically.” However, it was conceded that physicians constitute the cardinal factor.

Key to System

“The key to making the present system workable and acceptable is the physician and his medical society,” the committee staff said. “We are persuaded that at this point in time neither the government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

“While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health professions) to

do what is required with respect to monitoring care provided and charges made for the care. . . .

“However, procedures which involve peer review should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token.”

Report recommendations:

- Fee schedules for physicians’ services.

- Generic prescribing of drugs.

- “Curb overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment.”

- Require the patient to name a “primary physician” to end “costly ‘doctor shopping.’”

- Require states to provide medicaid recipients with statements outlining payments made in their behalf.

- Modify present law “to make practicable reasonable cost-sharing payments by the medically indigent.”

- Prohibit independent collection and discount agencies from collecting medicaid or medicare due bills that providers have sold to them.

- Improve federal administration, and establish cooperative arrangements with and between states.

- Establish a medicaid fraud and abuse unit in HEW, and require states to establish similar units.

- Combine the medicare and medicaid advisory councils.

AMA Urges Change

The American Medical Association urged changes in proposed federal regulations concerning fraud under the medicaid program.

“While we do not condone in any way any fraudulent conduct of physicians in Title XIX (medicaid) or in any professional activity, we do believe that physicians will consider the new requirements an unwarranted affront to their integrity in their participation in the program,” Dr. Ernest B. Howard, executive vice president of the AMA, said in a letter to John D. Twinn, acting administrator of the medicaid program.

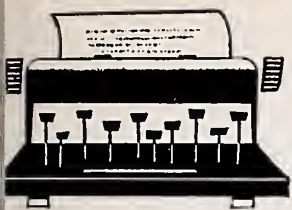
One of the proposed regulations would require physicians to sign form statements certifying that their claims were correct and that they understood fraud could subject them to prosecution.

Offensive Statements

These statements, Dr. Howard said, would serve no useful purpose because physicians already know that false claims could lead to prosecution. On the other hand, the regulation would be “regarded as offensive by many physicians since it obviously impugns their integrity,” the AMA letter said.

The other proposed regulation would require state agencies to promptly report suspected cases of fraud.

“It is obvious that serious prejudice may result to a physician where the suspicion of fraud is publicized,” the AMA said. “Even when the fraud is not later established, irreparable harm to the reputation of the physician will still have resulted. . . . We believe it will be better procedure not to report each suspected case, but to include in the report only those situations where the case has been concluded and fraud has been established.”



Cerebrovascular Disease and Oral Contraceptives

ANOVULATORY AGENTS, introduced several years ago for the prevention of pregnancy, have achieved widespread usefulness and acceptance. As with any active pharmacologic agent, a certain number of side effects have been encountered and some have been reported in the medical literature. As evidenced by the widespread consumption of these agents, it would seem apparent that any adverse clinical reactions have occurred in a minority of the total patients using them.

Increasingly, though, as more experience has been gained from the administration of these agents, reports have appeared in the literature implicating their potential for increasing the incidence of peripheral venous thrombosis in otherwise healthy young women. Of late, a few reports have appeared which have implicated the pill in occlusive disease of the cerebral vasculature. About one-fourth of the cases reported have involved the vertebrobasilar circulation of the brain. Other reported cerebral involvement has included pseudotumor cerebri in a small number of patients, ocular involvement with optic neuritis and retinal vascular involvement. The onset of migraine-like headaches has been reported in a small number of cases, but is considered under-reported by comparison with other cerebrovascular disease. The onset of hypertension has been observed in a small number of reported cases following the exhibition of the anovulatory agents in otherwise healthy young women.

In the reported cases of cerebral complications the average duration of usage has been a little more than nine months and the mean age about 29 years.

Even though a fair number of adverse reports have been accumulated, actually few instances have been recorded in which careful autopsy studies of the histology of the cerebral vasculature were carried out. In those studies which have been reported, a significant number have shown endothelial proliferation and sub-endothelial fibrosis in the small and medium-sized vessels, both at the site of thrombosis and where no thrombus was seen. This suggests that the changes in the blood vessels were primary. In none of these patients was evidence of underlying atherosclerosis found.

It is well-documented that healthy women during pregnancy or the puerperium may develop non-atherogenic stroke. Such strokes may also be seen in young women with various systemic connective tissue diseases, especially systemic lupus erythematosus. Strokes have been documented in young women having migraine naturally or induced, following the use of oral contraceptives. Each of these seems related closely with physiological or histological alterations of the vasculature of the brain.

Animal studies utilizing anovulatory hormones have been carried out, though they are limited. In rabbits, specific effects in large vessels including cerebral showed an increased amount of smooth muscle, a decrease in the proportion of collagen, marked fragmentation of reticulum, an apparent loss of elastic tissue and a marked loss of mucopolysaccharides. Qualitatively similar changes are found in rabbits during pregnancy. Interestingly, these changes are seen to revert to normal within a period of two weeks. One investigator has shown that in rats, chronic estrogen administration predisposes to vascular lesions resembling polyarteritis nodosa.

Fibro-muscular dysplasia of the renal arteries is seen predominantly in multiparous women. One investigator has speculated that this vessel change may be analogous to the cerebral vessel changes seen during pregnancy or following the administration of anovulatory agents.

In spite of the above observations it is interesting to note that there has been no recorded increase in cerebrovascular mortality in women of child-bearing age since the introduction of the pill. This may well be due to a concurrent reduction of cerebrovascular mortality in this age group from such other causes as pregnancy. No one would question that the pill has reduced the incidence of pregnancy in the general population.

With the data so far accumulated, one cannot prove or disprove a statistical association, but one is justified in calling attention to a possible increase in the frequency of idiopathic cerebrovascular disease in young women since the introduction of oral contraceptives.

REFERENCE

Dayton, S. et al.: *Annals of Internal Medicine* 72:1, pp. 111-121, 1970.

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MORE ON ADDITIONAL DUES

ON THIS PAGE, in an earlier edition of the *Journal*, an attempt was made to answer numerous questions and doubts that had arisen following passage of a bylaw by the House of Delegates of the Medical Association of Georgia. This bylaw called for a dues increase of \$100.00 for each member of the Association for the calendar year 1969. Though most of the members had been paying their \$40.00 yearly dues for years and years, without questioning where the money went, tacking on this extra amount for a single year affected certain individuals as though they had been struck with all nine tails of a cat o'nine tails in their most sensitive area—their pocketbook.

There is no doubt that this dues increase for 1969 came as a surprise to many members of MAG, but to anyone who had cared enough to follow the affairs of the Association for the past several years, the raising of additional money could be seen to be inevitable. First, there had been no raise in the annual dues for over 10 years, although such a raise had been recommended to the House of Delegates in numerous reports during the past several years. Secondly, the House of Delegates had instructed Council in 1968 to proceed with rather costly additions to, and refurbishing of, the Association headquarters building at 938 Peachtree Street, N.E. However, they had made no arrangements for the financing of the project. So, in 1969, the House of Delegates was faced with the problem of raising these funds; the addition to the bylaws passed at that time was its answer.

To anyone interested in MAG this should have come as not too much of a surprise. All the usual channels of communication were open; the *Journal* printed all the actions and recommendations of the Executive Committee, the Special Finance Committee of Council, Council and the House of Delegates. They were all openly discussed at Annual Session in 1968 and 1969. In addition each member, if interested, can always confer with his delegate to the MAG House on upcoming issues, although his councilor *should* keep his District and County Society advised as to what is going on. If a member is *really* interested, he can show a little initiative and seek out his councilor and ask him what has transpired at Council meetings, and what will come up at the next meeting of the House of Delegates. This applies to all matters financial and otherwise.

It has been stated that a poll of MAG members should have been taken before a dues increase was enacted. If this precedent were set, we could scrap the House of Delegates and our present form of representative government, wherein each member of our House of Representatives represents a percentage of the members of MAG.

It has been stated that the letter going to all members of the Association informing them of the action of the House of Delegates, which went out over the signatures of myself and the Secretary of the Association, was a "bad" letter, precipitous and insulting. I take issue with this. If the letter did indeed insult anyone, my apologies. But, having read and reread it, I fail to see anything insulting in it.

There was a certain deadline to meet so the letter was sent out as soon after the Annual Session as possible. The statement that any members in arrears after September 15 "shall be suspended" was quoted from the actions of the House of Delegates and was not that of the writers of the letter.

The question has been asked as to why and how the "deadline" for payment, as set forth by the House of Delegates, was changed by Council from September 15 to December 15, and now more recently until the meeting of the House in May, 1970. This is a good question. Council, in its wisdom, with more time to ponder the mechanics of the execution of this action by the House, felt, for the overall good of the Association, the 300 or so members who were slow in paying should be reminded again by letter and personally by their councilors of their obligation to pay. It was felt that many had simply "not gotten around to it yet." This has proven to be the case. The response has been good and only a few members of MAG have failed to meet this obligation. Historically, this is not the first time that the Executive branch of a governing body has closed one eye in the enforcing of actions of a Legislative body, when it thought it was for the good of the organization as a whole.

Some wag has referred to MAG headquarters as a "puzzle palace." Personally, I take exception to this; more appropriately it could be likened to a bee hive with everyone therein a worker, no drones, and all the workers putting out 100 per cent for the queen, in this case, MAG.

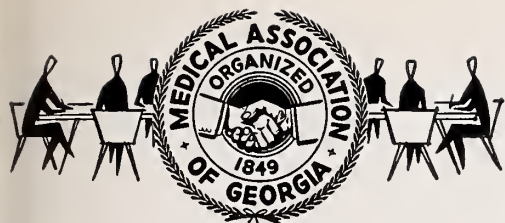
I would like to think that these words plus the many others already written answer most of the questions about action of the House of Delegates of MAG in May, 1969, and that the valuable time of the House in May, 1970, will not be taken up by dissidents and nit-pickers arguing about or questioning the actions of the House a year ago. Because of the hard work of a few—the Building Committee appointed by Council, the MAG staff and a few others—and the dollars, or hundred dollars of many, MAG now has a home office of which it can be proud, and in which its ever-expanding works can be efficiently carried out.



John Kirk Train, M.D.
President, Medical Association of Georgia

Seek facts and classify them and you will be the workmen of science. Conceive or accept theories and you will be their politicians.

—Nicholas Maurice Arthus



THE ASSOCIATION

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Rasmussen, E. P. Active—Fulton—R	1968 Peachtree Road, N.W. Atlanta, Georgia 30309
Saker, A. F. Active—Fulton—OBG	1311 E. Cleveland Ave. East Point, Georgia 30341
Stuart, William H. Active—Fulton—I	3312 Piedmont Rd., N.E. Atlanta, Georgia 30305
Tuma, Robert P. Active—Fulton—OTO	705 Juniper St., N.E. Atlanta, Georgia 30308

SOCIETIES

The **Peach Belt Medical Society** has named new officers for the coming year. They are as follows: F. M. Lindsey, president; Ronald G. Severs, secretary-treasurer, and O. D. Fussell, program chairman.

PERSONALS

First District

John Mooney spoke on alcoholism at the January meeting of the Muscogee County Medical Society.

Irving Victor, chief of urology at Memorial Medical Center, has volunteered for a 60-day tour of duty in a provincial civilian hospital in Vietnam, beginning in April.

Second District

Ed Aderholt spoke on drug use by college students at the January meeting of the Tifton Lions Club.

Third District

Joseph C. Serrato was honored by the Pan-American Development Foundation in January at a luncheon in Washington, D. C.

Fifth District

Ivan A. Backerman will be installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting, April 12-18, in New York City.

Bruce Logue addressed the Internist Society and lectured to the Heart Symposium in Chattanooga, Tenn. in January.

Sanford Matthews spoke on the many aspects of the Mother-Child relationship at the January meeting of the Temple Sinai Women's Committee.

Eighth District

Richard L. Benson is the newly elected Chief of the Medical Staff of Coffee General Hospital.

Don R. Roberts was inducted as a Fellow of the American Academy of Orthopedic Surgeons at the group's annual meeting in Chicago in January.

Tenth District

Samuel M. Goodrich will be installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting, April 12-18, in New York City.

Hamlin Graham was installed as a Fellow of the American Academy of Orthopedic Surgeons at the group's annual meeting in Chicago in January.

F. M. McElhannon is one of five U. S. physicians whose comments on the relationship and therapeutic implications of non-toxic nodular goiter to thyroid cancer are featured in the current issue of *Modern Medicine*, a leading national medical journal.

Deaths

William H. Tailer

William H. Tailer, Mayor of Darien and McIntosh County's only physician, died January 18 in a boating mishap. He was 49 years old.

A native of Alexandria, Va., he attended Duke University and graduated from the University of Michigan and the University of Buffalo Medical School. He interned and trained in pathology at Meyer Memorial Hospital in Buffalo.

Dr. Tailer was reelected in November to a second two-year term as mayor of the City of Darien. He organized the Darien-McIntosh Chamber of Commerce and was elected president for three years.

THE ASSOCIATION / Continued

He was a member of the Coastal Area Planning and Development Commission, the Community Action Committee, chairman of the Coastal Area Sports Fishing Federation, the McIntosh County Industrial Authority and McIntosh County Board of Health. He was a member of St. Andrew's Episcopal Church.

Dr. Tailer is survived by his widow, Mr. Kathryn Coddington Tailer; three sons, Timmie, Jimmy, Ray; five daughters, Mrs. Ginny Forbes, St. Simons, Miss Winnie Tailer, New York City, Misses Lindy, Cindy and Kathy, Brunswick; one brother, Peter L. Tailer, New York City; his parents, Mr. L. S. Tailer of Palm Springs, Calif., and Mrs. Catherine Harding of Paris, France.

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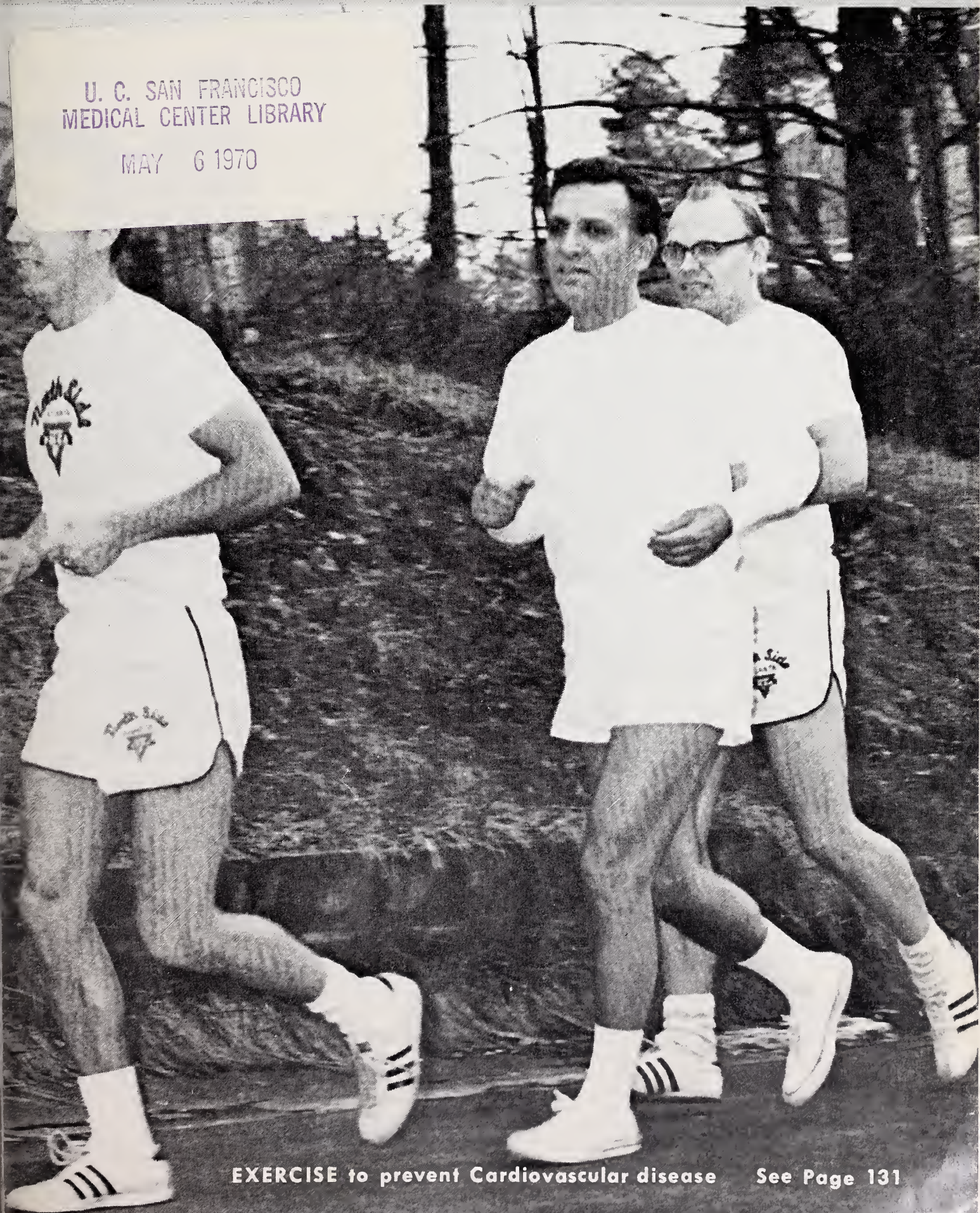
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EXERCISE to prevent Cardiovascular disease

See Page 131

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and jitteriness. In contrast, CNS depression has been reported. In a few epileptic an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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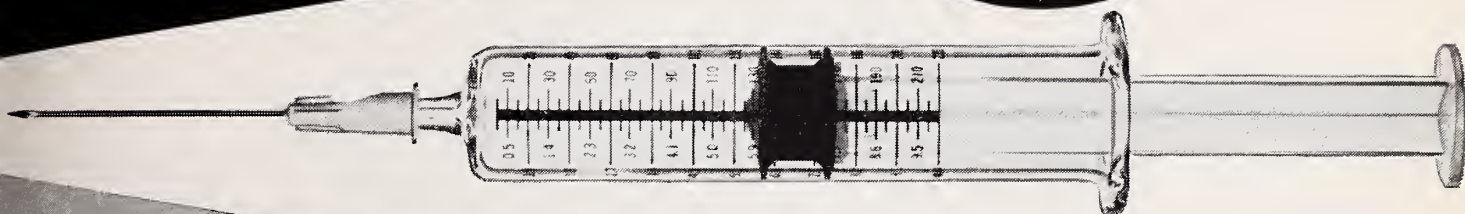
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Contents

See page 153 for 116th Annual Session
Motel Reservation Form.

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Scientific Articles

THE CHALLENGE OF PREVENTION OF CARDIOVASCULAR DISEASES Paul Dudley White, M.D.	131
BALL VARIANCE: POTENTIALLY LETHAL DEGENERATION OF THE STARR-EDWARDS AORTIC VALVE POPPET Thomas L. Crews, M.D., Martin J. Frank, M.D., Robert G. Ellison, M.D., J. Robert Teabeaut, M.D., and Harry T. Harper, III, M.D.	135
AN UNUSUAL CASE OF PHEOCHROMOCYTOMA James C. Thoroughman, M.D., Robert B. Smith, III, M.D., Victor Skorapa, Jr., M.D., and Donna Franco Jove, M.D.	143
SPONTANEOUS RUPTURE OF THE SPLEEN J. M. Owings, M.D., C. J. Wyatt, Jr., M.D., B. S. Brice, M.D., and J. H. Smith, M.D.	147

Special Article

MEDICAL MALPRACTICE VS. INDUSTRIAL MALPRACTICE Ernest F. Daniel, M.D., J.D.	140
--	-----

Clinical Note

WHEN ALL THE TESTS ARE NEGATIVE Leon Carter, Jr., M.D.	150
---	-----

Editorials

WELCOME TO JEKYLL FOR THE ANNUAL SESSION J. L. Owens, Jr., M.D.	154
HIGHLIGHTS 1970 GEORGIA GENERAL ASSEMBLY	154

Features

President's Letter	157
Atlanta Graduate Medical As- sembly	151
Cancer Page	159
Heart Page	161
Legal Page	163

The Association

Calendar	139
New Members	166
Societies	166
Personals	166
Deaths	167

Cover

UPI photographer Jeff Hodges snapped Earl McEntyre, Ray Newmark, and Bill Robinson during their regular early morning jog. Cover layout by Marie Seaman.

Attention to the prevention of arterial disease demands first priority.

The Challenge of Prevention of Cardiovascular Diseases

PAUL DUDLEY WHITE, M.D., *Boston, Mass.*

TWENTY YEARS AGO, or rather a little earlier, I became involved in the program of the National Heart Institute of the U.S. Public Health Service, in the summer of 1948, about one month after Congress passed the National Heart Act. I return thanks to those, especially to Duckett Jones, who personally involved me. I had just come back from Greece and Italy and was full of interest in that exchange visit we made there with the Greeks and the Italians.

I didn't listen to Dr. Jones at first. He finally got me to do down to Washington, which I had tried to avoid for many years, and I joined up. So I'm especially grateful for that prodding.

I came across an old book in my father's library that had not come to my attention before except to note the title, *Human Longevity*, which in the early days of my medical career had not interested me enough to read.

Much older now and coming across it again, I read some of the early pages. I want to quote to you some passages from the introduction.

The title page of this interesting volume reads as follows: "Human longevity, recording the name, age, place of residence and year of the deceased of 1,712 persons who attained a century and upwards from A.D. 66 to 1799, a period of 1,733 years."

These are all the recorded and reasonably authentic centenarians that he could find, up to 1799.

"—with anecdotes of the most remarkable, by James Easton."

The book was printed and sold by James Easton himself. On page 15 of the introduction appears the

following statement of relative duration of human existence as taken from Hufeland, and I wish somebody would tell me who Hufeland was. He probably was one of the first statisticians, I judge, on human longevity. Of a hundred men (probably meaning infants; I don't think just males) who were born, 50 died before the tenth year, 20 more between the tenth and the 20th, ten more between the 20th and 30th. That means 80 per cent before 30. Six died between the 30th and 40th, five between the 40th and 50th, three between the 50th and 60th. There weren't many left; therefore, only six lived to be the age of 60 or more. This was in 1799.

Quotation From the Book

On page 24 is the following quotation: "*Man is by nature a field animal and seems destined to rise with the sun and to spend a large portion of his time in the open air, to inure his body to robust exercises and the inclemency of the seasons*" (not carrying an umbrella, I judge), "*and to make a plain, homely repast only when hunger dictates.*"

"Art—this is another definition of art—has studiously defeated the kind intentions of nature, and by enslaving him to all the blandishments of sense has left him, alas, an easy victim to folly and caprice. To enumerate the various abuses which take place from earliest infancy and which are continued through the succeeding stages of life would exceed my limits. Suffice it to observe that they prevail more particularly among people who are the most highly polished and refined. To compare their artificial mode of life with that of nature or even with the long-livers of this work would probably afford a very striking contrast and, at the same time, supply

CHALLENGE / White

an additional reason why in very large cities instances of longevity are so very rare.

"Of late years, the increasing luxury and dissipation of the age, no longer confined to the metropolis" (that was London) "have spread their contagion far and wide into the country so as to afford the sage divine and the speculative moralist a more melancholy prospect of the apparent degeneracy of the human race than perhaps was ever before exhibited."

This was in 1799. Think what's happened since then.

Today's Epidemic

Now, let me come down to today. Some medical observers might think of me, I believe, as a medical Jeremiah when I state that probably the greatest epidemic of all time has descended upon the young and middle-aged males of this country during the last generation and upon the especially prosperous minorities of other lands around the globe who live the way most of our people do. This is an epidemic of serious atherosclerosis of the aorta, the coronary arteries, cerebral arterial blood supply, iliac and femoral arteries and blood vessels elsewhere, importantly complicated by thrombosis and pulmonary embolism.

And apparently wherever there's a lot of atherosclerosis, there's a lot of thrombosis. They go together. They are not the same disease, although some believe that atherosclerosis starts this way, i.e., by thrombosis. But there are a good many experienced observers who agree with me.

Let me quote briefly from the proceedings of the National Conference on Stress, Strain and Heart Disease held in March this year. Perhaps some of you were there. I wasn't. It was jointly sponsored by the Heart and Industry Committee and the Rehabilitation Committee of the American Heart Association.

One of these committee men—I belonged to both of them, I believe, years ago—who is an Associate Professor of Medicine at Western Reserve University, Cleveland, stated: "It is a fact that coronary disease is present in almost all adult males, that over 25 per cent of all heart attacks are completely silent (I don't know that I agree completely with that statement), and that most attacks are marked by absence of any precipitating factors. We know that coronary morbidity and mortality are lower for persons who engage in strenuous work. This makes it difficult to accept the myth that work-stress can be causally related to coronary disease; certainly it cannot conceivably have had a primary etiologic

significance in the genesis of the heart disease, presumably in childhood. Yet, through legal precedents and judgments, this has become an accepted fact. This disparity between the medical and legal concepts of causalities is a major problem yet to be resolved."

Economic Toll

During the same conference, the Assistant Vice-President of the Illinois Bell Telephone Company presented data indicating the economic toll extracted from industry by heart disease. In one recent year, he reported, there were 373 coronary deaths among 275,000 active employees. This wouldn't have been surprising at all if these were employees who were retired as well as active, but these were all active. I don't know what the data for the age of retirement is, but none of these were retired. This represented 27 times the number of deaths caused by accidents, physical accidents, work-related.

"It's estimated that of 1,000 male employees now at the age of 30, 56 will die of heart attacks before they reach the age of 60 while some 60 others will have non-fatal attacks by that time." That is 60 plus 56. You add them together and you get a figure which gives a considerable percentage out of 1,000.

Mr. Scroggle concluded that "the prevention of heart disease is just as important to industry as safety campaigns and accident prevention" and suggested that "support of the activities of its local heart association is one of the things that every business should undertake."

That's the end of the quote. To all of this I heartily agree. My second quote is from a summary I sent and from a conversation this morning. Fifty years ago when cardiologists were struggling to establish a new specialty before the days of the acceptance of cardiology as such, there were small groups of pioneers at several of the larger cities of the U.S.A.; in particular, New York, Boston, Philadelphia, Chicago and St. Louis, who called themselves Associations for the Prevention and Relief of Heart Disease.

I'm not sure this covered the whole country, but those were the chief centers at that time, which emphasized this priority of prevention. This priority of prevention followed the lead of Richard Cabot of Boston, who in 1914 had declared that the causes of heart disease were more important than the structural changes and the functional conditions.

For the next several decades, however, we were so involved in the excitement of new techniques and the resulting flood of new diagnoses and of the spectacular medical and surgical treatments that prevention of heart disease took a back seat and

received largely lip service, except for the brilliant control of the infectious diseases.

Prevention Important

Anyone will concede, I am sure, that much more important than the recent drama of transplantation of hearts or even of open heart surgery, is the prevention of arterial disease early in life, in the teenagers or even earlier, by better health habits with particular reference to the candidates, since serious atherosclerosis early in life can now often be identified. Attention to them demands the first priority. I'll cite three examples which I think are quite interesting.

Once I was asked about a 20-year-old son of a doctor who had a serum cholesterol of 650 mg. and also severe angina pectoris. He died at 21 of the coronary heart disease that he had. Both his parents had very high serum cholesterol, something like 350, I believe. That was an inherited disease; heredity played a major role. When we're going to be able to meet that challenge, I don't know, but it certainly is difficult to know what to do in such a particular situation. I don't think we need to insist there be a test of the serum cholesterol before marriage, but to be absolutely sure we really ought to.

Athlete With Heart Attack

It may be that we can do something about it in the parents as well as in the children. In another case, I was asked to go to Montreal about 10 years ago to see a patient in the Montreal General Hospital, a patient who was 28 years old, an athlete with a heart attack. I saw him on the third day of his heart attack. I was told I was to see him with a psychiatrist as well as with the family doctor.

When I questioned him, I didn't think he had any psychosis until I got to the last question, and then I asked, "What about your diet?"

This young man then said, "That's where they think I'm crazy."

I asked, "Why?"

"Well," he said, "for the last 10 years I've been in the habit of drinking 12 quarts of milk a day." And they confirmed that. I suspect that all that milk and cream in it overcame his athletic prowess.

Another Case

Two weeks ago at the Boston City Hospital I was asked to lead a medical grand rounds concerning a man of 38 who had recently run the annual Boston Marathon Race of three weeks earlier. He had finished the marathon race of 26 miles in apparently excellent condition, finishing hand-in-hand with two of his teammates from Canton, Ohio. They had all come on from Ohio and they had all finished, I be-

lieve, about an hour behind the winner, who broke the record. The winner was a young Japanese physical educator who did the 26 miles in two hours and 13 minutes, which is extraordinary.

Ten minutes after the end of the race, this 38-year-old man whom I was called to see at the City Hospital had a heart attack, an absolutely typical one. I came to see him during his uneventful convalescence.

The question is, why should he have had it in that way and why did he have it at all at 38? Then the story came out. He had been a vigorous athlete, but at the age of 25 he started a business that was extremely strenuous, very difficult. He was married about that time too, and the combination forced him, apparently, to give up all his athletic activities. He gained 40 pounds in the next few years. He began to smoke four packs of cigarettes a day. This went on for 12 years, from the age of 25 to the age of 37, and then in the fall of last year, he decided to do something about it. So, in his usual impetuous way, he quickly lost the 40 pounds, stopped smoking, and began to run. He ran hard, and he ran further and further, so finally when he was able to run 20 miles without any difficulty, he decided to enter the marathon race after only three or four months of training. He came on and ran the marathon.

Due for a Coronary

There were about two or three hundred young interns and residents in front of me, about 25 years old. This was a wonderful opportunity to explain why I thought anybody should realize that this man was due for a coronary heart attack even if he hadn't run the marathon. It might not have occurred at this time, but quite probably the marathon was a factor. He agreed that he probably shouldn't run any more marathons, but there's no reason why he shouldn't get back into condition. I suppose that he trained too fast for one thing, and he was really sick when he ran without being aware of his considerable coronary atherosclerosis. He was lucky, however, in the timing of his attack. I don't know whether anybody ever died during one of our Boston Marathons, but this man must have been close to it.

I think no one should have any coronary heart disease before they're 80, and I daresay we may stretch that eventually, though not for a while. I think that everybody should be able to shovel snow up to the age of 80, or at least to 70. Yet, we have a lot of deaths in New England from shoveling snow each year in the group from 35 to 75 years old, especially in the 45 to 65 group where many coro-

CHALLENGE / White

nary cases come much too early in life; so it isn't a matter of simply getting older.

Table I shows the candidates for early atherosclerosis. When I was in New Orleans two or three months ago at a meeting on cardiovascular epidemiology, I emphasized the risk factors you see on the left—first, heredity, which has been much neglected, and then the environment, which also may be inherited, but the fact that you can pick out many of the candidates early in life has been lost sight of. We don't yet know, as we should, how many we can pick out.

TABLE 1
YOUNG CANDIDATE FOR EARLY
ATHEROSCLEROSIS

- A. The genes (heredity)
 - 1. Male sex
 - 2. Body build—mesomorphy
 - 3. Hypercholesterolemia
 - 4. Diabetes mellitus in family
 - 5. Early coronary heart disease or stroke in both paternal and maternal ancestry
- B. Environment
 - 1. "Rich" diet and obesity
 - 2. Physical inactivity
 - 3. Tobacco—cigarettes (20 or more daily)
 - 4. Stress

Candidates for Atherosclerosis

Who are the candidates? Well, we know from our study 20 years ago that the mesomorph is certainly more of a candidate than the ectomorph, like myself. I was protected from birth, but this was good luck. This is heredity, and I've fortunately never gotten fat. In fact, they try to fatten me up now and then.

Among young coronary cases that we studied 20 years ago, 100 cases under the age of 40, there were many mesomorphs; the majority were mesomorphic; there was no pure ectomorph in the 100, not a single one like myself. That's important although that fact has been neglected and 97 per cent were male!

Another factor is hypercholesterolemia—if anybody continues to have a serum cholesterol percentage of over 300 mg. or even over 250 mg., he also is a candidate. Diabetes in the person or his relatives is also important. Or if there is coronary heart disease in the family. This we ought to know more about. We don't have good family histories as a rule. I don't think any patient can give us a proper family history yet; we've got to get the families themselves more involved. We've got to be able to know whether both father and mother died of coronary heart disease, or atherosclerosis of other

types such as strokes, under the age of 60 or even in the 60's because that is important, too. One relative is not enough, however. The father or mother may die of coronary heart disease in the 50's, perhaps, and the patient not be a candidate because he takes after the other side of the family, but if both father and mother are found to have died early of atherosclerotic disease, that is important. In a study of 100 of my own coronary cases recently compared with 100 controls, I found that the involvement of one parent may not be enough, but if both parents and brothers and sisters have coronary heart disease or strokes, then there is a greater likelihood for our subject in question to have it. We ought to know more of what is happening in the family and get better family histories. This is occasionally attempted, but it is not very well done yet.

I'll leave the rest of the risk factors due to environment, which may, incidentally, also be inherited, to those who will follow me. Thank you very much.

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All patients with a prosthetic aortic valve incorporating a silastic poppet should be followed closely and completely re-evaluated at least every six months.

Ball Variance: Potentially Lethal Degeneration of the Starr-Edwards Aortic Valve Poppet

THOMAS L. CREWS, M.D.,¹ MARTIN J. FRANK, M.D.,^{2, 3}
ROBERT G. ELLISON, M.D.,⁴ J. ROBERT TEABEAUT, M.D.,⁵ and
HARRY T. HARPER, III, M.D.,⁶ *Augusta*

SINCE ITS INTRODUCTION in 1961,¹ the Starr-Edwards caged ball valvular prosthesis has been widely accepted by cardiovascular surgeons throughout the world. Eight years later this prosthesis is the most popular type for aortic valve replacement. The problems of thromboembolism and increased red cell destruction have been viewed as acceptable risks when compared to the potential benefits. Long term anticoagulation has helped to alleviate the clotting problem. However, long term patient follow-up has revealed that degeneration of the silastic poppet of the valve constitutes an infrequent but serious and sometimes fatal complication. Recently the clinical diagnosis of ball variance has been aided greatly by the finding of reduced intensity of the opening sound of the prosthesis.² Hylen and Starr, et al., have found that using a ratio of aortic opening to aortic closing sounds recorded phonographically at the second right or intercostal space has been of aid in diagnosing ball variance. In short, if this ratio is less than 0.5, then ball variance is thought to be present.

This report concerns two patients seen at the Medical College of Georgia who were found to have ball variance.

Case Report #1

A 43-year-old white male truck driver was admitted to Talmadge Memorial Hospital on 6-25-63 with a 10-month history of dyspnea on exertion and a four-month history of orthopnea. Digitalis had been started five months prior to admission. Three weeks prior to admission the patient began to experience stinging left precordial pain. He gave no history of acute rheumatic fever, lues, recent febrile episodes, or night sweats. Physical examination revealed murmurs consistent with aortic insufficiency and aortic stenosis. Electrocardiogram showed normal sinus shythm and left ventricular hypertrophy of systolic overload type. Chest x-ray revealed moderate cardiomegaly with a ring of calcium in the aortic valve. Cardiac catheterization revealed a gradient of 40 mm Hg across the valve. On 7-25-63 the patient underwent aortic valve replacement with a number 9-A Starr-Edwards (series 1000) prosthesis. Following discharge, the patient did well and was able to work as a taxi driver. In 1964 the patient's digitalis was discontinued by his local physician. In April and June 1965, the patient had episodes of left anterior chest pain with radiation to the left arm. These were treated with nitroglycerine and pentaerythritol tetranitrate with improvement. He then did well until early 1967 when chest pain recurred. The patient was readmitted to Talmadge Hospital on 9-3-68 because of a history of increasing exertional dyspnea and increasing frequency of chest pain for eight months. He had experienced

¹ Fellow in Cardiology.

² Professor of Medicine, Director of Hemodynamic Laboratories, and Senior Investigator, Georgia Heart Association.

³ Address reprint requests to Martin J. Frank, M.D.

⁴ Professor of Surgery and Chief of Section of Thoracic Surgery.

⁵ Professor of Pathology.

⁶ Fellow in Cardiology.

From the Departments of Medicine, Surgery, and Pathology, Medical College of Georgia, Augusta, Georgia 30902. Supported in part by USPHS Training Grant HE 05442.

two-pillow orthopnea for six months despite re-institution of digitalis.

The blood pressure was 140/65, pulse rate 90 and regular, temperature 37. There were scattered wheezes in both lung fields posteriorly. The point of maximal impulse was 2 cm lateral to the midclavicular line in the 6th intercostal space. The opening click of the prosthesis was markedly diminished. A grade III/VI ejection systolic murmur was audible at the second right intercostal space and at the lower left sternal border. A grade II/VI holosystolic murmur was present at the apex with radiation to the left axilla. The murmur of aortic insufficiency was not heard. Electrocardiogram revealed sinus rhythm and incomplete left bundle branch block. Chest x-ray showed moderate cardiomegaly with a Starr-Edwards aortic prosthesis in place. The pulmonary vasculature was normal. Laboratory data included a hemoglobin of 10.7 gms, hematocrit 36 per cent, white count 8,600, and a reticulocyte count of 5.1 per cent. Serial EKGs and enzymes were normal. The patient improved with digitalis and anticoagulant therapy. A phonocardiogram obtained on this patient revealed an AO/AC ratio of .16 (Fig. 1). The patient refused catheterization and surgery



FIGURE 2

(Case #1) Poppet is opaque and swollen with deep grooves formed by the cage struts.

service in 1945 because of a heart murmur. He had been digitalized on 9-24-64. Physical examination revealed a blood pressure of 130/80; pulse 80/min and regular; respirations 18; and temperature 37. A systolic thrill was palpable in the primary aortic area and in the carotid vessels. A grade V/VI ejection systolic murmur, loudest at the second right intercostal space, was heard over the entire precordium and in the carotid vessels. A grade II/VI decrescendo, high-pitched, diastolic murmur was audible along the left lower sternal border. Electrocardiogram revealed complete left bundle branch block. Chest x-ray showed moderate cardiomegaly, due predominantly to left ventricular enlargement, and calcification of the aortic valve. Cardiac catheterization revealed an aortic gradient of 98 mm Hg. On 10-22-64 a heavily calcified tricuspid aortic valve was removed and replaced with a size 10 Starr-Edwards (series 1000) valve. Post-operative course was uneventful and the patient returned to work in approximately four months.

On January 20, 1969, the patient was readmitted to Talmadge Memorial Hospital with the chief complaint of dizzy spells. He had continued to work until February of 1968 when he was forced to stop working because of dizziness. Previous complications had included a cerebral embolus in June, 1967, with residual slight left-sided weakness, embolus to the right kidney in May, 1968, and two episodes of cardiac decompensation requiring hospitalization in the summer of 1968. Blood pressure was 140/100 and pulse 90/min. The point of maximal impulse was at the anterior axillary line. A systolic thrill was palpable in the aortic area. No comment was made concerning the prosthetic opening sound. A grade III/VI ejection type murmur was audible at the aortic area. A grade I/VI diastolic murmur was audible at the lower left sternal border. Electrocar-

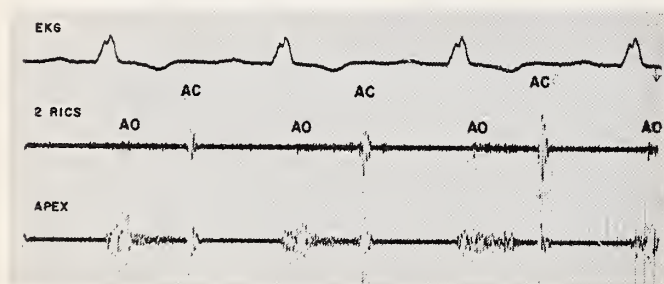


FIGURE 1

(Case #1) Phonocardiogram showing marked diminution of aortic opening sound (AO). Ratio of aortic opening to aortic closure sound (AO/AC) is 0.16.

and insisted on going home for one month to think over the possibility of submitting to further surgery. He was discharged on 9-18-68. On 10-29-68 he died suddenly at home. No unusual exertion preceded this event. The heart was obtained for study by the Department of Pathology, Medical College of Georgia. Figure 2 shows the prosthesis with the poppet swollen, grooved, and discolored. The ball moved in the cage only with great difficulty.

Case Report #2

A 37-year-old white male truck driver was admitted to the Talmadge Hospital on 10-15-64 with the chief complaint of shortness of breath for three years. The patient had been rejected from military

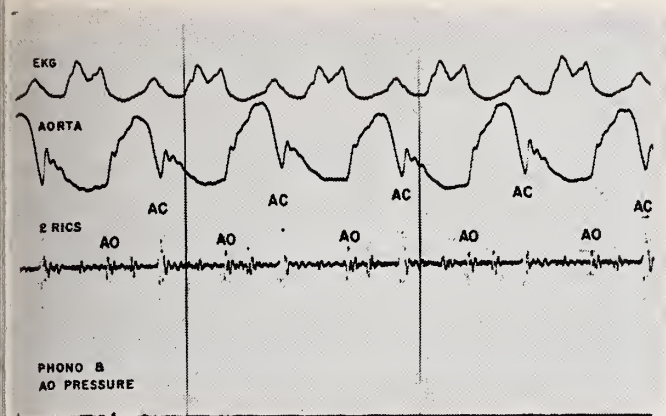


FIGURE 3

(Case #2) Phonocardiogram performed during catheterization shows an AO/AC ratio of 0.29.

diagram again revealed complete left bundle branch block. Chest x-ray showed considerable cardiomegaly with the heart size being about the same as pre-operatively. Phonocardiogram (Fig. 3) revealed AO/AC ratio of .29. Cardiac catheterization revealed a gradient of 39 mm Hg across the prosthetic valve.

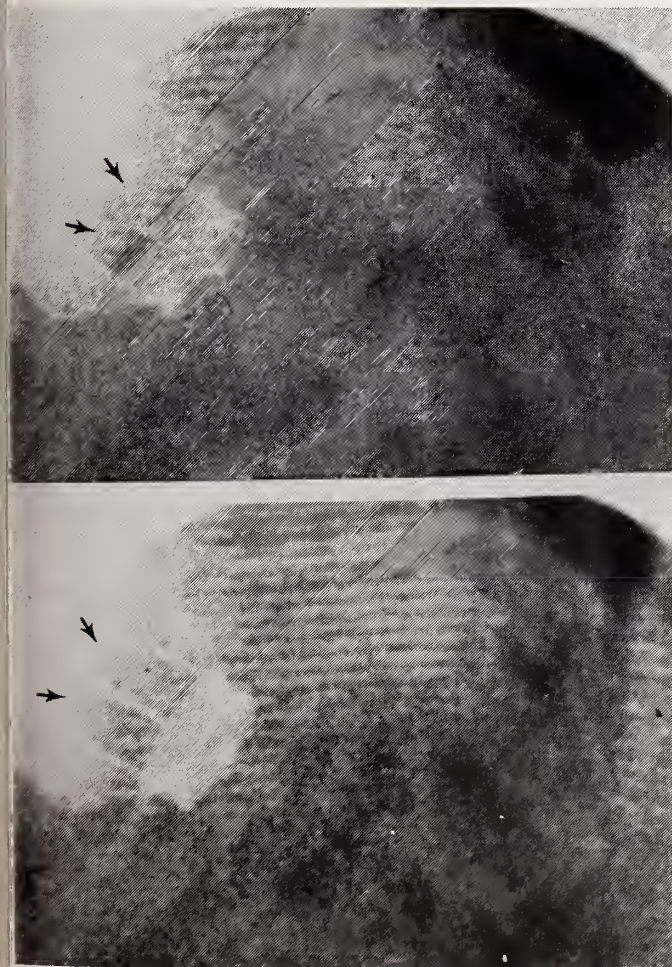


FIGURE 4

(Case #2) Upper illustration shows the poppet in negative relief during diastole. Lower figure shows the ball at the height of ejection. Note that the ball does not ascend to the top of the cage.

Cineangiography showed that the poppet did not ascend to the top of the cage with each systole (Fig. 4). There was also minimal aortic insufficiency present. A diagnosis of ball variance was made and the patient was scheduled to have the poppet replaced on January 27, 1969. However, on January 25, 1969 he suddenly developed ventricular fibrillation. Attempts at resuscitation were unsuccessful. At autopsy the silastic ball was found to be opaque, cracked, and swollen to the extent that it moved in the cage with great difficulty (Fig. 5). Other findings included a large, old infarction of the anterior lateral wall of the left ventricle and a re-canalized thrombus of the right coronary artery. In addition, the left bundle branch of the heart was calcified.

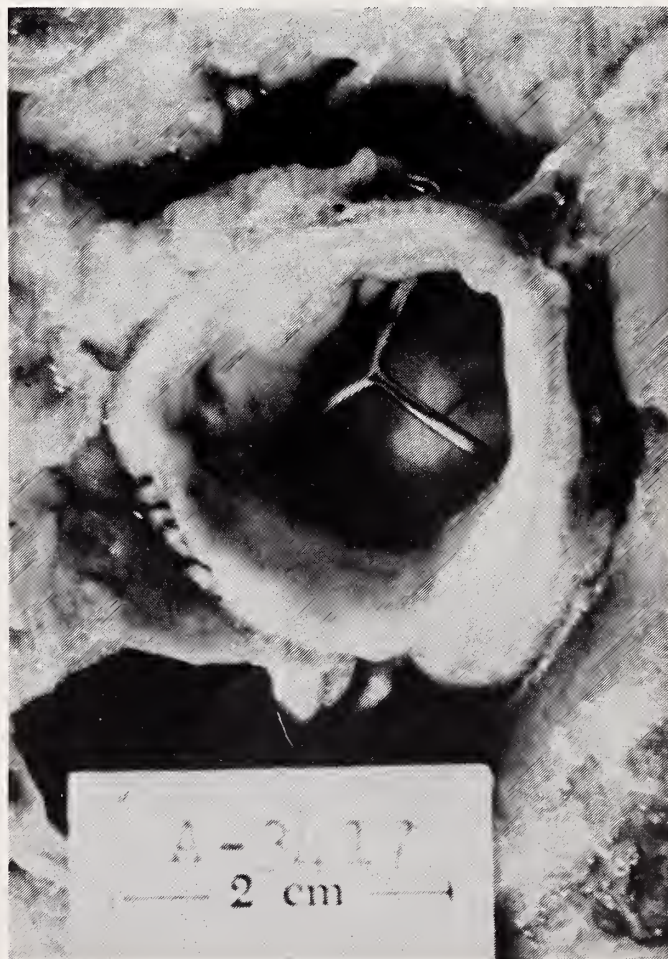


FIGURE 5

(Case #2) Silastic ball is swollen, opaque, and cracked. The ball could be moved only with great difficulty.

Discussion

The material used in the construction of the poppet for the Starr-Edwards aortic prosthesis is medical grade silicone rubber (Silastic #372, Dow Corning). The stated physical characteristics of this material include: biological inertness; resistance to deterioration and fragmentation; limited porosity, permeability, and absorption or abstraction characteris-

ties; resistance to changes in temperature or chemical environment; and mechanical endurance to compression, acceleration, impact, and abrasion.^{3, 4} In addition, extensive in vitro testing with an accelerated fatigue test pump has shown no evidence of ball degeneration after stress, equivalent to 45 years of in vivo use.¹ However, degeneration of the silastic ball has become an accepted clinical entity.^{2, 3, 5-13} In an earlier review of this problem, Starr, et al.,⁴ felt that most cases of ball variance exhibited some abnormality of implantation. These included a major leak around the prosthesis, impingement of the aortic root on the ball pathway, impingement of the cloth sewing margin on the ball pathway, and restriction of the ball pathway by clots. Newman, et al.,⁸ felt that impingement of the wall of the aorta upon the ball pathway occurred when the ball was oriented away from the axis of the aorta or when the valve was too tight a fit in the aortic root. In addition, they postulated that the presence of a mass of calcium in the valve ring adjacent to the ball might hasten erosion of the ball surface. Chemical analysis of the degenerated poppets has revealed the presence of fatty acids in the silicone material.⁴

Reviewing their experience in this area, Hylen and Starr, et al.,³ have documented the occurrence of ball variance in 20 per cent of patients with aortic valve replacements who live longer than 12 months following surgery. The average time from surgery to the diagnosis of ball variance was 40 months (range 29-52 months). Others¹⁰ found that none of their patients dying less than 24 months after aortic valve replacement had evidence of ball variance. However, all of 12 patients dying more than 24 months after aortic valve replacement had varying degrees of ball degeneration. In the latter group, the deformed poppet was thought to be the cause of death in 11 of the 12 patients. Eight of these 11 patients died suddenly and unexpectedly, and were allegedly asymptomatic at the time of death. The problem of ball variance has not previously been significant with mitral prostheses. However, two cases of mitral ball valve prosthetic malfunction secondary to a swollen poppet have been reported.¹⁴

Early Diagnosis Imperative

Early diagnosis and treatment of the complication of ball variance has become imperative. The late onset of syncope, undue fatigue, recurrent angina, palpitation, congestive heart failure, hemolytic anemia, and late embolic episodes have been thought to

suggest the possibility of this complication.^{2, 3, 5} The most frequently associated findings are the late occurrence of a diastolic murmur of aortic regurgitation and the loss of the prosthetic valve ejection click on auscultation. When the murmur of aortic regurgitation is intermittent, it is a particularly significant physical finding suggesting ball variance.⁶ The phonocardiogram has been thought to be a valuable aid in confirming the loss of the ejection click of the prosthetic valve. Hylen, Starr, et al.³ found that when the intensity of the aortic opening sound became less than half that of the aortic closure sound, ball variance or an abnormality of the cage was present in 10 of the 12 patients tested. False positives with this method were due to clot formation on the cage structure. We can confirm the finding that an AO/AC ratio of less than 0.5 suggests significant ball variance. In both cases cited in this report the AO/AC ratio was considerably less than 0.5.

In October, 1967,³ a new type Starr-Edwards prosthesis, utilizing a Stellite ball, became available. No case of ball variance has been reported with this prosthesis.

In all patients with an aortic valve prosthesis containing a silastic poppet, phonocardiograms should be done every six months, and more frequently if symptoms occur. Cardiac catheterization may provide additional evidence by demonstrating an increased gradient across the aortic valve, and cineangiography may aid by showing the movement of the ball in negative relief. This could be seen clearly in our second patient. Since the metal cage is narrower at the superior portion than at the base, the swollen ball will be unable to hit the top of the cage, thereby accounting for the diminution of the aortic opening sound. Figure 4 clearly demonstrates this.

Summary

Both patients presented in this report had series 1000 prosthetic valves. Until recently, all cases of ball variance reported had occurred in prosthetic valves of this series. However, there have been recent reports¹⁵ of four cases of ball variance in the 1200 series of prosthetic valves.

There are now a large number of patients in Georgia who have had their aortic valves replaced by a caged ball prosthesis. It is imperative that all patients with an aortic valve prosthesis containing a silastic poppet be closely followed, both by their family physician and by the medical centers where their valve replacements were performed. Careful physical examination and phonocardiogram should be performed at least every six months, and if symp-

ptoms occur or the phonocardiogram is suggestive, cardiac catheterization should not be delayed.

Medical College of Georgia

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CALENDAR OF MEETINGS

In Georgia

May 7-10—Teamwork Management of Chronic Obstructive Pulmonary Diseases, Stuckey's Carriage Inn, Jekyll Island

May 7-10—Medical Association of Georgia, 116th Annual Session, Jekyll Island

May 12-15—Pesticides and Public Health, U.S. Food and Drug Administration, Atlanta

May 18-22—Control of Mosquito-Borne Diseases, Savannah

In the Nation

May 3—Council on Environmental and Public Health, Statler Hilton Hotel, Washington, D.C.

May 4-5—Congress on Environmental Health, Statler Hilton Hotel, Washington, D.C.

May 5—Residency Review Committee for Plastic Surgery, Brown Palace Hotel, Denver, Colo.

May 6-8—Medical Intensive Care and Coronary Care, St. Paul's Hospital, Vancouver, British Columbia

May 7-8—Third National Conference on Voluntary Health, Statler Hilton Hotel, Washington, D.C.

May 7-8—Residency Review Committee for Orthopedic Surgery, Hilton Inn West, Akron, Ohio

May 8-9—Council on Drugs, AMA Headquarters, Chicago, Ill.

May 9-10—Committee on Health Care of the Poor, Chicago, Ill.

May 12—Residency Review Committee for Physical Medicine and Rehabilitation, O'Hare Inn, Des Plaines, Ill.

May 13-16—Postgraduate Trauma Course, John B. Murphy Auditorium, Chicago, Ill.

May 14-15—Committee on Transfusion and Transplantation, Washington, D.C.

May 14-16—AMA Board of Trustees, Washington, D.C.

May 15-17—Council on Legislative Activities, Chicago, Ill.

May 18-19—Residency Review Committee in Internal Medicine, Knickerbocker Hotel, Chicago, Ill.

May 20-22—Clinical Aspects of Infectious Diseases, University of Washington School of Medicine, Seattle, Wash.

May 22-23—Council on Occupational Health, Drake Hotel, Chicago, Ill.

May 23-24—Committee on Medical Aspects of Sports, Drake Hotel, Chicago, Ill.

May 27-28—Residency Review Committee for Obstetrics and Gynecology, Homestead Hotel, Hot Springs, Va.

May 30-31—Conference Committee on Graduate Education in Surgery, Drake Hotel, Chicago, Ill.

*The author advances some suggestions
for curbing the unrealistic awards
which result from malpractice suits.*

Special Article

Medical Malpractice VS. Industrial Malpractice

ERNEST F. DANIEL, M.D., J.D., *Augusta*

MEDICAL MALPRACTICE IS A CRIME. Industrial malpractice is a respected state. It wasn't always this way. In the past, they both were crimes. In the mind of the public the cost of medical treatment is a crime. The cost of industrial products is understood and accepted. It wasn't always this way. In the past, the industrialist was the hood.

What changed all this? I don't really know, but I believe it's because industry did something about it. Now it's our turn to act.

In recent months, physicians have repeatedly been bombarded with requests, pleas, and threats, all directed to the high cost of medical attention. Indeed, the only thing missing from this mass of missiles hurled at the medical profession is an offer to help. Inflation is beyond our control. In fact, only a few causes of the increased medical care costs are controllable; but one of these that might be controlled is excessive malpractice awards.

Program of Control

With help from our legislators and congressmen, we might start a program to control the unrealistic awards that result from malpractice suits and, hence, secondarily affect the cost of medical attention to the American public. However we attack this problem of unrealistic awards, it must be attacked with a program based on precedent. The lawmakers are not going to develop a plan for us; we have to plan our course and then seek their aid.

As with any program, we should select a place to begin; and one does not begin by having everyone galloping off in a different direction to joust his own windmill, but by making a concerted effort against the enemy. I say this advisedly because the medical community will never get together until we

consider these factors enemies. It is important that we do get together and that our thoughts on the subject be presented to the public, not just discussed in secret by physicians only.

Many people agree that a \$200 to \$300 increase in the amount of malpractice insurance rates is such a relatively small amount of doctors' expenses that it does not increase the cost of medical practice. I maintain that many x-rays are made, many tests are performed, and many patients are admitted for medico-legal reasons rather than for wholly medical reasons. I also maintain that this, in time, will be an increasing deterrent to young men and women becoming physicians; and I believe that there are many in our profession who agree with this viewpoint. Even though the doctor may be well insured, he is faced with the possibility of losing that protection if he is sued, either by cancellation of his insurance or at least by being called upon for payment of exorbitant awards which may greatly exceed his insurance coverage. These high awards work against both patient and physician.

Open Letter

"The Physicians Management" published an open letter by Dr. G. B. Markle, IV, of Carlsbad, New Mexico. In this letter, addressed to Wilbur Cohen, Secretary of HEW, Dr. Markle makes this statement, "if failure to save a life by negligence or gross error can lose a doctor half-a-million, then he should charge the patient half-a-million when he saves a life." Dr. Markle goes on to say that, of course, this is impractical. But I say that what he states is logical; and since it is impractical to raise fees, the practical thing to do is lower awards.

How many times a year have physicians seen or

read of awards being made without regard to the extra skill required to obtain a good result? The expectation of miracles has become commonplace, and the physician who does not live up to this expectation is punished. Why isn't a cripple restored to health worth as much as a cripple caused by a surgical accident? Yet, if the medical profession charged \$100,000 for a medical cure, this would be regarded as a crime. The reverse is not true and is not regarded as criminal by the general public. In fact, the lawyer who can obtain such an award is considered smart. It is totally unfair to allow a disability to cost a physician or insurance company \$100,000 when the disability could be worth only \$10,000 if covered by workmen's compensation.

Workmen's Compensation, I believe, is the answer to the exorbitant malpractice awards being given in this country today. Therefore, it is worthwhile that we, as physicians, discuss the background of workmen's compensation. The whole idea of workmen's compensation was to protect industry while it got started, and it is certainly true that the medical profession needs to be protected today.

Compensation Principle

The Compensation Principle apparently originated with the adoption of the German Compensation Act in 1884. I say apparently because I am sure that there is nothing new under the sun. Since that was also true in 1884, it must have started earlier; and I don't care to get in any controversy about it. Basically, the Compensation Act takes injuries to workmen from under the old principle that an employer might be sued for injury caused by himself, assistants, or employees' fellow workers. In turn, for giving up these rights, the employees were given quicker settlements, surer settlements, and settlements based on their earnings. For example: little might it matter that an employee of that date had a potential million-dollar law suit. If his influential employer could keep it from coming to trial long enough, the employee might easily starve to death while waiting for the court decision. He was much better off to take the lesser amount and to have it more assured.

It was found that, as more industrial accidents occurred, unlimited liability became an impossibility and would indeed seriously retard the industrial revolution. Medical advancements are just as seriously threatened today.

Common law based the employer's liability upon the grounds of negligence; but negligence is merely the disregard of some duty imposed by law. It may not even be negligence in the ordinary sense of the word, only a statutory duty. Oftentimes, the fault

may be that of the employer; but frequently it is the fault of some other person for whose conduct the employer has been made responsible by statute . . . many times a person not directly under his control.

We see this counterpart even more dramatically demonstrated today in the medical world. I think this is most easily recognized in those instances where one works in a hospital and has no control whatsoever of who is hired or fired by the hospital administrator or hospital authority.

Law of Work

Under the common law of work, the employee assumes the risk normally expected to accompany the occupation in which he is voluntarily engaged. If he were injured under such circumstances, through no fault of the employer, he then had no lawsuit whatsoever. However, under the Compensation Principle, at least he would get some aid no matter who was to blame. As a result, very few employers are made to feel guilty because the employee got hurt on the job . . . even though he does assume part of the risk. It is a valid conclusion, therefore, that medical insurance could be and should be limited to this same type reasoning; that is, a person suffering a very poor operative result would get some payment similar to that received by a workman under the Compensation Act without casting a shadow of guilt upon the physician who is doing his best and without subjecting him to an enormous malpractice coverage and adverse publicity. It just does not follow that a man can suffer an injury on the job worth a few hundred dollars . . . whereas if the same injury is suffered at surgery, it will be worth a few thousand dollars.

In essence, the workmen's compensation statute imposes liability on the employer to make compensation for disability or death to an employee when this results from an accidental personal injury suffered in the course of this employment; and this is without regard to fault, except where the employee intentionally tries to injure himself or where he totally disregards all safety regulations and is guilty of a large degree of contributory negligence. For example, in the medical field, this would be comparable to prematurely removing a cast in case of certain broken limbs. However, by being eligible for medical benefits and some percentage of his earnings, he automatically gives up the right to sue for larger amounts.

I see no reason why this general concept of insurance could not be transferred to people seeking medical attention. Today, an accident in a factory is thought of in just those terms by the general public; whereas, an accident in the operating room is con-

sidered as something evil and deserving punishment to all involved.

While it is true that no one can be made to accept this principle by his individual physician, it might be set up in a legal manner or a physician might even elect not to operate on anyone that would not accept this principle in the same manner that an employer does not have to hire employees who will not accept the Workmen's Compensation Principle. Theoretically, the employee has the right to deny the Workmen's Compensation Principle and reserve his right to sue. As a practical manner, however, no one would hire anyone who reserves this right. We do have one great difference in the two analogies. We are not hiring, we are being hired; but we do have something that the patient wants even more than a job.

How to Begin

Now, assuming that we all agree this program is worthwhile, how do we get started? I know that every patient is not going to give up his inalienable right to sue his doctor because this is part of the time-honored, doctor-patient relationship so well projected in song and verse. We have to first select the group to be attacked and then proceed with the same techniques used and developed so well by our government in order to feed us mud pies and call it chocolate cake. This is the unobtrusive wedge technique.

We enter the wedge at the same point that it has already been entered . . . the point of least resistance. That is, the group that has already been subjected to workmen's compensation laws. This is also the group that allows a comparison of the cost of injuries caused by careless employees and protected by the law with those caused by a physician who is not protected by the law.

Once the beachhead has been established, we merely tap the wedge a few times. The first tap will include those retired from jobs, which had been under workmen's compensation; and of course, there is only another step and another tap to that large group under government rolls or pensions. Finally, the whole population is engulfed in a wave larger than even Social Security. I cannot think of a larger simile.

Help Ourselves

There is no reason that while trying to control the cost of medicine we cannot help ourselves at the same time. The double standard of protecting the businessman and sacrificing the professional

man is certainly not based on any justice. It is really based on the facts that the businessman is not held back by illogically based altruism, he is not ashamed to fight for what he believes because of fear of what someone might say about it; and because he is a businessman, he takes the time to tend to business. Politicians, of course, recognize this. They are, in the main, legally trained or businessmen. The professional man makes the mistake of trying to reason with politicians and trying to make them see problems logically.

Although I have tried to convince my own profession by logic, I am sure this would impress relatively few politicians. They have to be approached by an organized force, be given support when certain programs are carried out, and have this support withdrawn when certain programs are not carried out. This has to be done on a highly organized basis; and it is really the only "logic" that is recognized by our representatives.

In fact, while we are on the subject of logic, the most illogical logic in the English language may be found in court decisions. The judges, usually past politicians, will often reminisce about past decisions for several pages; quote any number of judges' famous sayings, out of context; and then, after a long series of incomplete sentences filled with whereases, arrive at a conclusion. Other judges do better. They decide the issue and then apparently send a law clerk over to the library to find their reasons. But I have digressed due no doubt to my legal training. It is imperative that our profession get together on some common goal. Making a man feel a little safer in the profession is one sure way of getting more qualified people in this profession. And that alone would help lower the price of medicine.

Ratification of a ceiling that might be placed on malpractice suits is certainly needed, and I feel that we should try to get this recognized as a legal principle. We can get this done only by letting the general public know our feelings by not being afraid to speak out, and by doing it in an organized manner. We can do it only by offering something in return to the public and the Workmen's Compensation Principle does this in a fair manner.

1467 Harper Street

What people call their conscience . . . is just the cancer that eats away the self.

—T. S. Eliot

Although pheochromocytomas are relatively common tumors, the case history of this patient is presented because of the extra-adrenal location of the tumor, the initial erroneous histologic diagnosis and certain technical problems associated with the surgical removal.

An Unusual Case of Pheochromocytoma

JAMES C. THOROUGHMAN, M.D., ROBERT B. SMITH, III, M.D.,
VICTOR SKORAPA, JR., M.D., and DONNA FRANCO JOVE, M.D., Atlanta

R.S.H., A 48-YEAR-OLD WHITE MALE, was admitted to another hospital in November, 1968, complaining of bright rectal bleeding for one month. The source of his bleeding was found to be a rectosigmoid polyp which, on removal through a sigmoidoscope, proved to be a benign adenoma. While in the hospital an eight centimeter in diameter, epigastric mass was detected on physical examination and an exploratory laparotomy was performed. At operation the mass was in the retroperitoneum between the inferior vena cava and the aorta, apparently involving the renal vessels bilaterally. Neither kidney nor adrenal structures were thought to be invaded. Cardiac rhythm disturbances during the operative procedure prevented attempt at excision of the mass. A biopsy was interpreted by the local pathologist and also by the Armed Forces Institute of Pathology as "hemangiopericytoma." The results of the vanilmandelic acid (VMA) studies were not available. One week after operation the patient was referred to the Atlanta Veterans Administration Hospital for definitive therapy.

Physical examination at this hospital demonstrated a well-developed, well-nourished man, 5' 7" tall, weighing 149 pounds. His blood pressure was 130/90 and pulse rate was 100. The mid-line abdominal wound was well healed. On abdominal examination, the epigastric mass was palpated and found to be slightly tender and deeply fixed. Past history was non-contributory except for frequent occipital headaches and an unsubstantiated diagnosis of hypertension. Laboratory studies including hemogram, serum electrolytes, serum proteins, SGOT, SGPT, bilirubin, alkaline phosphatase, calcium, BUN, prothrombin time, VDRL, and glucose tolerance test were all within normal limits. Stool Guaiac tests and

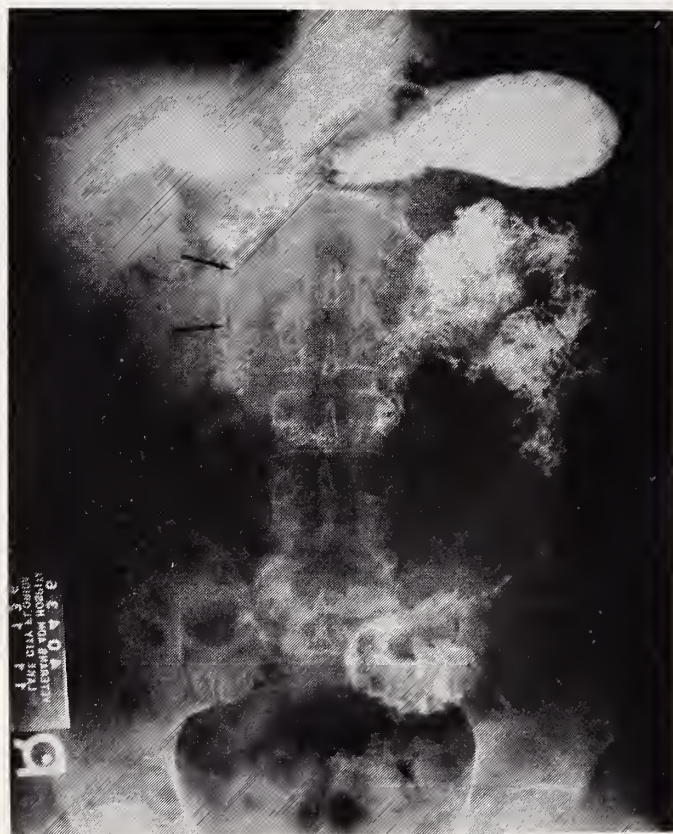


FIGURE 1

Sharply defined impression on medial aspect of descending duodenum.

several urinalyses were negative. Urinary and serum amylase examinations were normal; 5-hydroxyindoleacetic acid studies were normal. Electrocardiogram showed no abnormality. Roentgenograms of the chest were unremarkable except for cystic changes involving the right apical region. Plain films of the abdomen demonstrated narrowing of the intervertebral spaces between L₄ and L₅ and between L₅ and S₁. A gastrointestinal series showed anterior displacement of the descending duodenum and extrinsic pressure on its medial aspect (Fig. 1).

From the Surgical, Radiological, and Pathology Services, Veterans Administration Hospital, Atlanta, Georgia, and the Emory University School of Medicine, Atlanta, Georgia.



FIGURE 2

Lateral arcuate deviation of doubled right ureter.

A bifid collecting system of the right kidney was apparent on intravenous pyelogram, as well as complete duplication of the right ureter. The proximal course of the doubled right ureter was displaced laterally, along with clockwise rotation of the right kidney on its vertical axis and rightward displacement of the lower pole (Fig. 2). An aortogram performed by catheter insertion through the right femoral artery indicated a right upper quadrant



FIGURE 3

Stretching of right renal artery and its primary branches with upward and lateral displacement.

mass on the basis of arcuate upward displacement of the right renal artery and arcuate left lateral displacement of the superior mesenteric artery (Fig. 3). No abnormal vessels or tumor "blush" were evident on the aortogram. An inferior vena cavagram revealed marked arcuate deviation of the upper portion of the inferior vena cava to the right and extrinsic pressure on its medial aspect producing local constriction with evidence of partial obstruction (Fig. 4).



FIGURE 4

Sharp deviation to the right of the inferior vena cava at the level of the kidney and considerable narrowing of its lumen by medially disposed extrinsic tissue.

Abdominal Exploration

One week after admission re-exploration of the abdomen was undertaken with a preoperative diagnosis of retroperitoneal hemangiopericytoma. At operation the duodenum was found to be flattened and densely adherent to the anterior surface of a large, spherical, retroperitoneal tumor. A Kocher maneuver was performed and by sharp dissection the duodenum and pancreas were dissected from the underlying tumor. Numerous dense adhesions were noted on the anterior surface of the vena cava and sharp dissection was required to expose this structure from a point above the renal veins to the iliac veins. During manipulations incident to freeing the inferior pole of the tumor from the posterior abdominal wall, several episodes of systemic hyper-

tension and multiple premature ventricular contractions occurred. These circulatory changes were controlled by Lidocaine and Phentolamine and by temporary release of pressure on the mass. As the dissection progressed, it became evident that the tumor was well circumscribed and, therefore, resectable, but that it was tightly wedged behind the inferior vena cava at the confluence of the renal veins (Fig. 5). Consequently, the inferior vena cava was transected 4 cm. below the renal veins and its cephalad end reflected anteriorly to permit separation of the tumor from its posterior wall and from the adventitia of the aorta. Neither renal artery was found to be involved by the tumor and no significant artery from the aorta to the tumor was demonstrated. After the 190 gram mass had been removed intact, the vena cava was reanastomosed and the abdomen closed. Anticoagulants were not utilized.

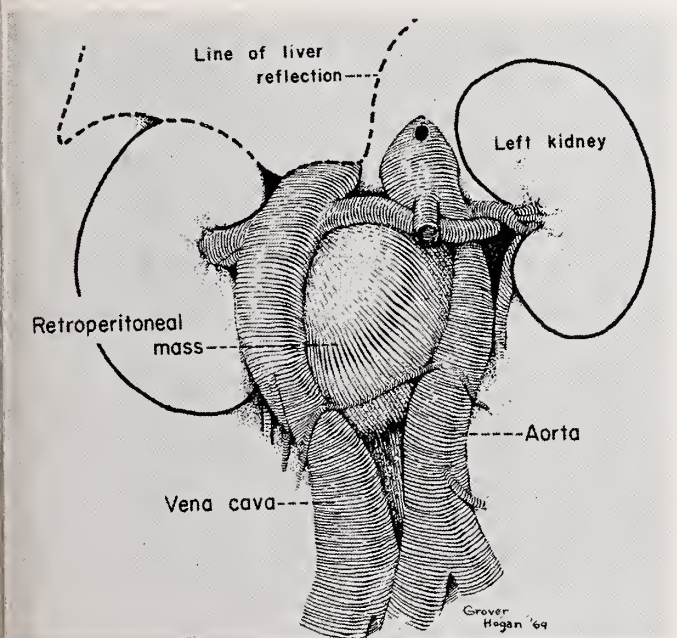


FIGURE 5

Artist's presentation of size and location of the tumor mass.

Systemic blood pressure readings which had been 150/80 at the conclusion of surgery stabilized at an average of 115/75 on subsequent days. His recovery was uneventful until the ninth postoperative day when he was noted to have abdominal distention and vomiting. Abdominal x-rays showed findings consistent with partial obstruction. This complication responded to decompression of the small bowel by a Miller-Abbott tube and he was discharged with his wound well healed on the 21st postoperative day.

Lab Reports

At the time of discharge reports became available from a commercial laboratory which confirmed

elevated vanilmandelic acid levels on two 24-hour urine specimens collected at the first hospital: 25.0 mgm VMA/24 hr, and 30.4 mgm VMA/24 hr (Normal=less than 10 mgm/24 hrs.). A final 24-hour urinary VMA collection obtained one week after complete removal of the tumor was subsequently reported to be 6.0 mgm/24 hrs. Sections of the mass removed at the time of the last operation were interpreted by the Pathologist as "pheochromocytoma." This final diagnosis was further supported by tissue bioassay which revealed 5.4 mgm norepinephrine per gram of tumor tissue and 1.9 mgm of epinephrine per gram. At follow-up two months after discharge the patient was in excellent condition and remained normotensive.

Discussion

The extra-adrenal location of this retroperitoneal pheochromocytoma is of interest. Ninety-nine per cent of pheochromocytomas are found within the abdominal cavity, but the majority, 60 per cent, are located within the adrenal glands.² Extra-adrenal abdominal pheochromocytomas have been found associated with the organ of Zuckerkandl in the area of origin of the inferior mesenteric artery, and in areas of discrete chromaffin tissue associated with the paravertebral sympathetics, as well as the celiac, mesenteric and hypogastric ganglia. In addition, they have been found in connection with renal, testicular, ovarian, bladder and prevesical structures. The remaining few extra-abdominal tumors are found within the thorax, and extremely rarely, in the area of the carotid body.

In the patient under consideration, the erroneous biopsy diagnosis of "hemangiopericytoma" resulted in less than ideal preoperative preparation for a definitive resection, although the possibility of a functioning pheochromocytoma was considered prior to the second operation on the basis of the history of headaches and hypertension, as well as the cardiac irregularities reported from the first procedure. Further diagnostic studies could have been performed, but the decision was made to proceed with early definitive surgery in the hope that scarring related to the original laparotomy would not have reached the stage that resection of the tumor might be technically impossible. Even at that early date, dense vascular adhesions had already formed, making dissection exceedingly difficult.

Technical problems experienced in removal of the large, inaccessible mass were further complicated by the patient's circulatory instability. However, the acute systemic hypertension and premature ventricular contractions were successfully managed by the same techniques that would have been followed had the diagnosis of pheochromocytoma

been definitely established earlier.¹ Intravenous Lidocaine and Phentolamine provided excellent control. Fortunately, the postoperative problems of hypovolemia and hypotension so common following pheochromocytoma excision did not occur in this individual, and unusual efforts at blood volume restoration or pressor drug administration were not necessary. Although there was no histologic evidence of malignancy on multiple sections of the tumor, extended follow-up examinations with hormone excretion studies will be necessary to detect recurrent or metastatic functioning pheochromocytoma in this patient.

Summary

The case history of a patient with a large, extra-adrenal retroperitoneal pheochromocytoma is presented to illustrate some of the difficulties of diagnosis and operation. Division and reanastomosis of the inferior vena cava is a useful technical maneuver which may facilitate removal of an otherwise inaccessible retroperitoneal tumor.

Veterans Administration Hospital

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The heart . . . moves of itself and does not stop unless forever.

—Leonardo da Vinci

AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY WOMEN'S AUXILIARY PRIZE—THE HANS BERGER AWARD

The Women's Auxiliary of the American Electroencephalographic Society offers an annual award, known as the Hans Berger Award, of \$300.00 for a meritorious manuscript dealing with electroencephalography, either clinical or experimental. Eligibility for the award is limited to individuals at pre-doctoral (Ph.D. or M.D.) and early post-doctoral levels. Candidates shall not be more than five years post-doctoral or two years post-residency.

Manuscripts should be submitted by June 1, 1970 to:

Dr. Reginald G. Bickford, Program Chairman, Neurosciences Department, School of Medicine, University of California at San Diego, La Jolla, California 92037.

The paper selected will be included as part of the Society's scheduled scientific program. A paper which has been submitted to the Program Committee for regular presentation may also be considered for the award. In this case, the *full* manuscript must be submitted to the Program Committee with the notation that it is submitted for consideration for the award.

COURSE ON EMERGENCY CARE

A four-day advanced course on emergency care and transportation of sick and injured persons will be held in Atlanta June 3-6, 1970, at Georgia State University.

Sponsored by the American Academy of Orthopaedic Surgeons, the course is designed for experienced first aid personnel interested in advanced training with emphasis on the instruction of others in emergency care.

Invited to attend are ambulance personnel, police officers, firemen, members of rescue and first aid squads, safety engineers, and others responsible for emergency care of the public.

Wells Is Director

Directing the course is Dr. Robert E. Wells, Atlanta orthopaedic surgeon and President-Elect, Fulton County Medical Society.

Faculty members of Emory University School of Medicine and others will conduct the advanced practical sessions offered by the Academy in cooperation with Georgia State University, Georgia Traffic and Safety Council, and the Fulton County Medical Society.

For information and registration forms, contact the course chairman, Robert E. Wells, M.D., 1938 Peachtree Road, N.W., Atlanta, Georgia 30309.

Spontaneous Rupture of the Spleen

J. M. OWINGS, M.D.,* C. J. WYATT, JR., M.D., B. S. BRICE, M.D.,
and J. H. SMITH, M.D., Rome

RUPTURE OF THE SPLEEN is a condition in which abdominal exploration and splenectomy are mandatory. Although splenic rupture most commonly results from non-penetrating abdominal injury,⁶ on rare occasion the normal spleen can rupture spontaneously.^{5, 8}

Since the symptoms in either case are identical, splenic rupture should be ruled out whenever compatible findings are present. If not, time wasted in observing the patient and delay in institution of proper treatment may result, as illustrated by the following case.

Case Report

This 27-year-old white male was seen on October 14, 1967 complaining of vague abdominal discomfort, non-productive cough, and general malaise of several days duration. One week earlier he had been treated symptomatically for a painful left shoulder occurring after some heavy lifting. There had been no previous hospitalizations, serious illness or injuries. He was employed as a janitor, smoked one pack of cigarettes per day and had never used alcoholic beverages. No abnormalities could be detected on physical exam; he was given a tranquilizer and told to return if the symptoms worsened.

He was brought to the emergency room the following morning at 1:30 a.m. after being awakened by a severe left upper abdominal pain, constant since onset. Temperature was 101, pulse 100, respirations 40 and blood pressure 120/90. Decreased breath sounds were noted at the left lung base, the abdomen was firm with moderate tenderness in the left upper quadrant. Chest and abdominal films showed a small infiltrate in the left lower lung, no free abdominal air and the stomach did not appear displaced (Fig. 1). The hematocrit was 23 per cent,

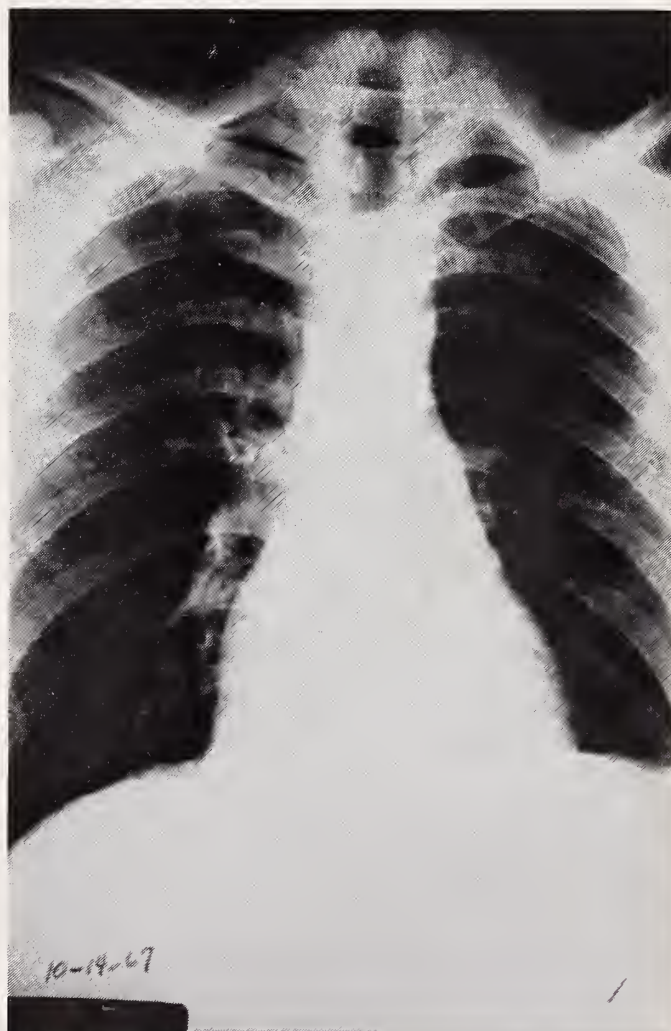


FIGURE 1

white blood count 10,300, urinalysis normal and serum amylase not elevated. A stool specimen was positive for blood.

The patient denied any history of anemia, and stated that he had never had hematemesis, melena or rectal bleeding. He was admitted with a diagnosis of pneumonia and anemia possibly secondary to GI bleeding and started on antibiotics, ulcer diet and antacids.

* Dr. Owings is now Resident in Surgery, Greenville General Hospital, Greenville, South Carolina 29601.

Diagnosis of Rupture

He was much improved on the second and afebrile by the third hospital day. A repeat hematocrit was 23 per cent and he was given two units of whole blood. Upper GI series the fourth hospital day showed the presence of a large left upper quadrant mass displacing the stomach anteriorly and to the right (Fig. 2). Although the patient, his family and fellow workers denied any knowledge of recent trauma, a diagnosis of rupture of the spleen was made and the patient was scheduled for exploratory surgery.



FIGURE 2

As his hematocrit was 30 per cent he was given two more units of blood immediately prior to surgery. While receiving the second unit, he had sudden onset of left upper quadrant pain and spiked a fever of 102. Moderate abdominal rigidity and increased left upper quadrant tenderness were present and the spleen or a left upper quadrant mass could now be felt for the first time. It was elected to

delay surgery temporarily and keep the patient under close observation.

The patient's symptoms gradually improved and he was afebrile by the eighth hospital day. On the 10th hospital day the abdomen was explored through a left paramedian incision. Approximately 2,000 cc of organizing hematoma was present about the spleen which had a large laceration on its anterior surface. Except for the changes associated with laceration and hemorrhage the spleen was grossly and histologically normal. The patient had an uncomplicated postoperative course and was discharged on the fifth postoperative day.

Comment

Failure to consider rupture of the spleen because of the absence of a history of trauma led to a delay in diagnosis and treatment which could have had serious consequences for this patient. Although spontaneous rupture of the spleen simulating pneumonia, as in this case, has been reported,² the findings are more commonly those of acute surgical abdomen. In an extensive review by Orloff and Peskin (1958),⁵ in 28 cases of spontaneous rupture of the normal spleen the correct diagnosis was made preoperatively in only one instance in spite of symptoms typical of splenic rupture. In over 50 per cent of these cases the preoperative diagnosis was perforated peptic ulcer and in 75 per cent the incision was placed so that splenectomy was difficult or impossible without a second incision.

Trivial or forgotten trauma may produce rupture and frank splenic rupture may be delayed.^{3,7} A sudden increase in abdominal pressure, as with lifting or defecation, may be a potential cause of trauma and produce rupture.^{1,4} In these instances, as with spontaneous rupture, lack of history of trauma may prevent the physician from considering rupture of the spleen. Making the diagnosis may be obvious or difficult but the first step is thinking of it. Failure to do so may have detrimental and even fatal consequences for the patient.

Summary

The occurrence of spontaneous rupture of the spleen is discussed. The importance of consideration and early diagnosis of splenic rupture is stressed.

Floyd Hospital

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LEADERSHIP CONFERENCE

A conference is sponsored each year by the Medical Association of Georgia Public Service Committee in order to better assist new county medical society officers in their duties. All county society officers attending this year's conference felt it was very rewarding, since most officers were not aware of the many services available through MAG. A new County Society Officers Handbook was distributed to the officers present at the conference. This handbook will relate some of the services available through MAG and the activities carried on through the various departments. The handbook is available upon request by various county society officers and will be distributed as the MAG Field Representative travels throughout the state.

The conference itself was divided into panel discussions with a period of time set aside for questions and answers at the end of each panel. Topics discussed included responsibilities of the County Society President and Secretary. It was determined that many county medical societies can effectively use the part-time services of a local Executive Secretary. Duties and responsibilities which could be delegated to an Executive Secretary in order to carry on a more active and efficient operation on the county medical society level were discussed.

Many areas were covered concerning the AMA and its expanding services available to physicians. The point was stressed that the AMA represents the physician and what the physician would like to see happen in medicine.

On a state level, it was stressed that each physician in Georgia is a vital part of the MAG organization and that he should understand how he can become a more effective leader in the field of medicine through MAG activities. Many ways were cited for MAG members to become more effective in county and state society activities.

Active Role

The MAG has always played an active role of leadership in all areas related to medicine and government programs. Physicians in Georgia have always determined to play an active part and to take a leadership role in all areas involving the government and medicine. One of the panels covered responsibility in involvement in such programs as Comprehensive Health Planning, Georgia Regional Medical Program and new developments in Medicare and Medicaid in Georgia.

No program can be complete without expressing the importance of Allied Health Recruiting and ways this can be more effectively carried out through a program involving the county medical societies. Each county medical society was encouraged to actively participate in programs of recruitment for medical and allied health personnel. A summary was also given of the Emergency Health Services provided through the State Health Department and ways physicians can participate through a more effective plan of Emergency Preparedness in case of a local or national disaster.

The program ended on a high note with an inspirational talk by Mr. William Curry, WAGA-TV Sports Newscaster and Professional Football player for the Baltimore Colts. The 12th Annual Medical Societies Leadership Conference helped Georgia physicians determine to set leadership patterns for medicine in Georgia.

Be on the lookout for future issues of the *Journal of the Medical Association of Georgia*, when talks given by several of the participants on the program will be reproduced. These articles will contain valuable information for you and your county medical society.

12TH CONGRESS, PAN-PACIFIC SURGICAL ASSOCIATION SCHEDULED FOR 1972

The Twelfth Congress of the Pan-Pacific Surgical Association will meet February 26-March 3, 1972, at the Hilton Hawaiian Village Hotel, Honolulu, Hawaii.

Concurrent meetings will be held in Anesthesiology, Colon and Anorectal Surgery, General Surgery, Neu-

rosurgery, Obstetrics and Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Thoracic-Cardiovascular, and Urology.

For details, write: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

When All the Tests Are Negative

LEON CARTER, JR., M.D., *Decatur*

HAVING BEEN in the general practice of medicine for the past 10 years, I have found that a certain percentage of patients present themselves with one or more of the following complaints: headache, indigestion, dizziness, vomiting, muscular aches or pains, listlessness, or lack of initiative. These patients vary between the ages of 30 and 50, and are usually married, have children, and are working members of our society. The paradox is that these people should be the happiest, most well adjusted, and have the greatest confidence in the future, but in actual practice they are not.

After a complete physical examination to rule out organic disease, the patient is sometimes referred for appropriate consultation and further radiologic studies. The percentage of these who require further study is very small, however. There are more females than males in my series, but the number is not appreciable.

Discussion with the patient following the physical exam frequently brings out emotional problems. The actual situation confronting the patients is, of course, not usually the same. Whether the problem is with the spouse, with teen-age children, with beligerent boss or with relatives is ordinarily immaterial. The two main ingredients of most of the patient's neurosis is with two intangible, immeasurable qualities, fear and guilt.

Definition of Fear

Fear is defined by Webster as "a feeling of anxiety and agitation caused by the presence or nearness of danger, evil, or pain." The patient will frequently state that his fear is due to a great dread of some event in the future, such as death, losing a job, or losing a loved one, such as a spouse, or a child by marriage. One patient stated that she feared that her husband would run off with his secretary, and another had a great fear of expressing herself freely to her boss, which she was afraid would cause her to lose her job. A 42-year-old sales executive was apprehensive that he might lose some of his better

customers due to the fact that he was not able to do what he considered an adequate job on each account. To those of us who practice medicine these fears might seem in these cases trivial, but to the patient they are "mountainous."

Offering the patient sympathy or merely giving reassurance is sometimes harmful and rarely helpful. I find that the most helpful method is to ask the patient, "what is the worst thing that could happen if the feared event took place?" Most of the patients think about this for a week and return to state that after considering this question and its consequence they not only felt better but that their presenting symptom had disappeared. Granted, the solution of the neurosis was not always this easy, but in a sizable number of cases they improved.

The other intangible feeling, "guilt," presents a more complicated problem, the entire depth of which I cannot cover in this short paper. The feeling of guilt refers to a person's having done an act of wrong or feels that he has committed such an act. In the majority of cases that I encounter in my practice extensive psychoanalysis or probing into the patient's subconscious are not necessary.

Necessary Action

What is necessary is asking the patient about any guilt feelings he may have and allowing him time to express himself concerning these. One man between the ages mentioned previously was deeply concerned over having physically beaten his wife in the past. A woman stated that she felt guilty over not doing all that was possible for her invalid mother before she died. A young minister had guilt feelings about expressing himself too freely about the building of a new church. These are a few of the many examples of guilt that occur with patients. Some of these are depressed because of their feelings, but the depression is usually mild. Reassuring these patients that no great punishment will happen to them for their "wrong" act is part of my treatment of these patients, and frequently it is all that is neces-

sary. When they return for follow-up visits they sometimes are completely rid of their symptoms. Occasionally, psychiatric referral is necessary for the more severe of these patients.

In summary I would like to restate that in the patients that I see in my office practice whose com-

plaints have no organic basis, I frequently find that feelings of fear and guilt are part of the symptoms and resolution of these two feelings is nearly always helpful in promoting a cure.

231 E. Ponce de Leon Ave.

27TH ANNUAL SESSION, ATLANTA GRADUATE MEDICAL ASSEMBLY

One of the most successful meetings of the Atlanta Graduate Medical Assembly was completed on March 10, 1970 at the Marriott Motor Hotel in Atlanta. Total registration was more than 2,000, with physician registration nearly 1,300. The meeting began on Sunday, March 8 with three simultaneous meetings, "A Day of Anesthesiology," "A Day of Gastroenterology," and "A Day of Pediatrics." The Day of Anesthesiology was jointly sponsored by the Greater Atlanta Society of Anesthesiologists. Dr. James D. Jones organized this day. Guest speakers included Leonard W. Fabian of Jackson, Miss., and C. R. Stephen of Dallas, Tex. Attendance was excellent at the entire meeting and the day was ended by a cocktail party given by the Greater Atlanta Society of Anesthesiologists for members, wives, and the visiting speakers.

Dr. Joseph Wilson was in charge of organizing a Day of Gastroenterology. Speakers included Dr. Harold J. Fallon of Chapel Hill, N.C., Dr. Colin G. Thomas and Dr. John T. Sessions also of Chapel Hill.

The Day of Pediatrics was organized by Dr. Joseph Yampolsky. Outstanding speakers included Dr. Douglas Maynard of Winston-Salem, N.C., Dr. Alex Haller of Baltimore, Md., and Dr. Samuel L. Katz of Durham, N.C. This was the first meeting in several years with a Day of Pediatrics and attendance was good.

Monday Session

Monday, March 9 included a Day of Surgery, a Day of Cardiology, and a Day of Obstetrics and Gynecology. The Day of Surgery was organized by Dr. Charles Todd and faculty included Dr. René Menguy of Chicago, Dr. Rupert Turnbull of Cleveland, Dr. James Pollard of Boston, and Dr. William Shingleton of Durham, N.C. This day was jointly sponsored by the Georgia Chapter of the American College of Surgeons, and the day was ended by a cocktail party for members, wives, and visiting speakers sponsored by the Georgia Chapter. Attendance on this day was outstanding.

Dr. Joseph Wilson also organized the Day of Cardiology which was co-sponsored by the Georgia Heart Association. Speakers included Dr. Henry J. L. Marriott of St. Petersburg, Fla., Dr. Jim Warren of Columbus, Ohio, and Dr. Harvey Estes of Durham, N.C. Attendance was excellent throughout the day.

The Day of Obstetrics and Gynecology was organized by Dr. Samuel R. Poliakoff and co-sponsored by the Atlanta Obstetrical and Gynecological Society. Speakers included Dr. Frederick C. Battaglia of Denver, Dr. Edward H. Hon of Los Angeles, and Dr. Edward J. Guillian also of Los Angeles. Attendance on this day was also unusually good.

The final day of the meeting was divided between a

Day of Cancer and a Day of Nephrology. Dr. Charles Todd organized this day in cooperation with the Georgia Division of the American Cancer Society. The day was saddened by the news that Dr. James T. Grace, Jr., of Buffalo, N.Y., had been involved in a very serious automobile accident in which his wife was killed the day before he was to leave for the Graduate Assembly. Dr. Rupert P. Turnbull of Cleveland, Dr. Felix N. Rutledge of Houston, Dr. Oliver Beahrs of Rochester, Minn., Dr. Justin Stein of Los Angeles, and Dr. Thomas C. Hall of Rochester combined to present an outstanding day which highlighted a tumor board conference at the end of the day. The Cancer Room was packed throughout the day with an enthusiastic audience.

The Day of Nephrology was organized by Dr. Joseph Wilson. Dr. Victor Murdaugh of Pittsburgh, Pa., Dr. James Melby of Boston, Dr. Earl Ginn of Nashville, Tenn., and Dr. George Schreiner of Washington, D.C., presented an outstanding program.

A review of the program in comparison with other similar meetings throughout the United States certainly indicates, to me, that the Atlanta Graduate Medical Assembly has developed one of the strongest postgraduate education efforts anywhere in the country. Its popularity with the physicians is shown not only by the 1,300 who registered but by the fact that they came from 12 states. It also seemed that there were more medical students, interns and residents at this year's meeting, which I feel is an evidence of the high quality of the presentations offered. The meeting would not have been possible without the cooperation of the Executive Committee, which includes Dr. Charles Todd, Faculty and Curriculum Chairman; Dr. Samuel Poliakoff, Exhibits Chairman; Dr. Joseph Wilson, Audio Visual Chairman; Dr. Duncan Shepard, Hospitality Chairman; and last but certainly not least, Mrs. George Hopkins, Executive Secretary.

The activities planned for the ladies who attended the meeting with their husbands were under the direction of Mrs. Edwin C. Evans, Chairman; Mrs. August B. Turner, Co-Chairman; Mrs. Joseph S. Wilson, Hospitality Chairman; Mrs. George S. Niles, Jr., Chairman Ladies Registration; Mrs. Richard King, Chairman, Paging; and Mrs. David Dennison, President of the Woman's Auxiliary to the Fulton County Medical Society. These activities included lunch at Underground Atlanta on Monday and a luncheon and fashion show on Tuesday. Both these events were extremely well received by the visiting ladies.

The Fulton County Medical Society is to be congratulated for sponsoring this outstanding event.

J. Gordon Barrow, M.D.

General Chairman

Atlanta Graduate Medical Assembly

*Shuttle Bus:
(Bus leaves from
the hotels marked
with Asterisk).
Schedule to be published
in JMG Program Issue
March 1970.



JEKYLL ISLAND

Points of Interest and Convenience

1. Shopping center, Authority office, post office, police.
- *2. Aquarama containing 2,500 seat convention hall with indoor heated pool.
3. South public bath house.
- *4. Corsair Motel and Restaurant.
- *5. Buccaneer Motel and Restaurant.
- *6. Carriage Inn Motel and Restaurant.
7. South picnic area.
8. Parking area.
9. Beach concession stand.
10. Ocean-side golf course.
11. Golf clubhouse and miniature golf course.
12. Eighteen-hole championship golf course.
13. Beach walk—1¾ miles fronting ocean.
14. North public bath house.
15. Beach concession stand.
- *16. Wanderer Motel and Restaurant.
- *17. Jekyll Estates Motel.
18. Oakgrove residential area.
19. Palmetto residential area.
20. Jekyll Beach residential area.
21. North picnic area.
22. Cherokee Campground.
23. Driftwood Beach.
24. Clam Creek fishing and picnic area.
25. Ruins of Major Horton's House.
26. Historical DuBignon Cemetery.
27. Ruins of Georgia's first brewery.
28. Picnic Area.
29. Plantation residential area.
30. Paved airstrip.
31. Pinegrove residential area.
32. Auditorium.
33. Faith Chapel.
34. All-weather tennis courts and clubhouse.
35. Jekyll Club Hotel and Village Area.
36. Jekyll Island Marina and boat docks.
37. Jekyll Island Museum.
38. Picnic Area.
39. St. Andrews residential area.
40. Miniature golf course.
41. Proposed Teen Center.
42. Beach casino and recreational area.
43. St. Andrews Auditorium.
44. Proposed yacht basin.
- *45. Seafarer.

1970 SHUTTLE BUS SCHEDULE MAY 7, 8, 9 AND SUNDAY, MAY 10

LEAVING TIMES FROM LOCATIONS AS INDICATED

Thursday, Friday, Saturday

Wanderer Seafarer Jekyll Estates	Stuckey's Carriage Inn
<i>Leaving</i>	<i>Leaving</i>
7:30 a.m.	7:45 a.m.
8:00	8:15
8:30	8:45
9:00	9:15
9:30	9:45
10:00	10:15
10:30	10:45
11:00	11:15
11:30	11:45
12:01 p.m.	12:15 p.m.

Lunch Break Coach Operator 12:15 p.m.—1:15 p.m.

1:30 p.m.	1:15 p.m.
2:00	1:45
2:30	2:15
3:00	2:45
3:30	3:15
4:00	3:45
4:30	4:15
5:00	4:45
5:30	5:15
6:00	5:45
	6:15

(End Service for Day
at the Wanderer 6:30 p.m.)

Sunday, May 10

Wanderer Seafarer Jekyll Estates	Stuckey's Carriage Inn
<i>Leaving</i>	<i>Leaving</i>
8:30 a.m.	8:45 a.m.
9:00	9:15
9:30	9:45
10:00	10:15
10:30	10:45
11:00	11:15
11:30	11:45
12:01 p.m.	12:15 p.m.

(End Sunday Service)
(At Wanderer 12:30 p.m.)

Medical Association of Georgia

Annual Session

May 7-10, 1970—Jekyll Island, Georgia

RESERVATION REQUEST

1. Please complete this form and mail directly to: Reservation Department
(Motel of your choice)
Jekyll Island, Ga. 31520
2. Special reservation forms will be mailed to Officers, Councilors, Delegates and Special Out-of-State Guest Speakers.
3. Assignment of rooms will be made in the order of receipt of reservation. If possible confirmation will be in accordance with preference indicated, if not, best substitute will be made.
4. Unreserved accommodations will be released on April 23, 1970.
5. A deposit in the amount of one night's lodging, plus 3% Georgia State sales tax, is required to assure your reservation. Make check payable to motel of your choice.
6. Rooms will not be ready for occupancy until 3:00 p.m. on day of arrival. Check-out time is 12:00 noon on your departure date.
7. A quick check out card will be placed in each room. Turn this in at Registration Desk and you will be billed later.

DAILY MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Name of Motel		Bedroom 1-2 persons	Kitchenette 1-2 persons	Each Additional Person
Buccaneer Motor Lodge	(Ocean)	\$17-20	\$20-24	\$1.00
	(Court)	\$16-18	\$18.00	\$1.00
Corsair Motel	(Ocean)	\$21.00	\$22.00	\$2.00
	(Drive)	\$18.00	\$19.00	\$2.00
Stuckey's Carriage Inn	(Pool)	\$21.00		\$2.00
	(Drive)	\$19.00		\$2.00
Wanderer Motel	(Ocean)	\$20.00	\$21-26	\$2.00
	(Drive)	\$17.00		\$2.00
Seafarer Motel	(Drive)	\$14.00	\$16.00	
Jekyll Estates Motel	(Ocean)	\$18.00		

ALL RATES PLUS 3% GEORGIA STATE SALES TAX

Cut out and send to motel of your choice:

Please type or print

MEDICAL ASSOCIATION OF GEORGIA ANNUAL SESSION

MAY 7-10, 1970

NAME

ADDRESS

CITY & STATE ZIP

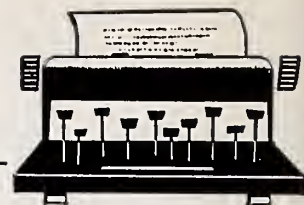
ARRIVAL DATE DEPARTURE DATE

I DESIRE ACCOMMODATIONS AT (1st) (2nd) MOTEL.....

TYPE ACCOMMODATIONS DESIRED FOR # OF PERSONS

I DESIRE TRANSPORTATION FROM TO MOTEL

FLIGHT # TIME



Welcome to Jekyll for the Annual Session

ON BEHALF of the Glynn County Medical Society a cordial welcome is extended to you for the Annual Session to be held on Jekyll. We hope that you will bring the family and enjoy our many recreational facilities during the time of the meeting. The last Session held on Jekyll was one of the best attended on record and we sincerely hope the forthcoming one will likewise be so.

In addition to the beach and the Aquarama with a year-round swimming pool, one has four golf courses within easy driving range; one on Jekyll, two on St. Simons Island, and one in Brunswick. The fishing is excellent in the spring and there is a new fishing pier constructed on the north end of the Island.

Picturesque Sea Island, St. Simons Island, and Jekyll Island are all available for sightseeing. Also, due to the fact that this is a resort area, there are many excellent dining facilities.

If Society members can be of any help in arranging your stay on Jekyll please write: The Glynn County Medical Society, 3010 Hampton Avenue, Brunswick, Georgia 31520.

*J. L. Owens, Jr., M.D., President
Glynn County Medical Society*

Highlights 1970 Georgia General Assembly

The following is a summary of some of the legislation of interest to the Medical Association of Georgia that was considered during the 1970 session of the Georgia General Assembly. As of this writing none of these bills have been signed into law by the Governor. Under Georgia law he has 30 days following adjournment of the General Assembly, excluding Sundays, in which to sign or veto bills or permit them to become law without his signature.

STERILIZATION: THE 1970 AMENDMENTS to the Georgia sterilization statutes will make possible a sterilization procedure to be performed in two areas not legally possible prior to the enactment of this bill. Prior to enactment of the 1970 bill, the only persons who could be considered for sterilization were married persons, and then only with the consent of the spouse. Under the new Act, any person 21-years-old, married or unmarried, may request such a procedure. If the subject is married the consent of the spouse is required, if he (or she) can be located pursuant to a reasonable search.

The second important change relates to sterilization of the mentally incompetent. The bill incorporates numerous safeguards including appointment by the Ordinary of two "disinterested" physicians to investigate the matter and report back to the

court, consultations, performance of the procedure in JCAH hospitals, and, of course, written consent on the part of the parents or guardian.

PROFESSIONAL CORPORATIONS: The Professional Corporation Act, for the first time, permits a single professional practitioner to incorporate his practice for the purpose of availing himself of certain tax, profit-sharing and retirement benefits in the same manner that non-professional corporate entities are now permitted to engage. This bill would not in any way limit a physician's professional liability.

CADAVERS: The so-called "Dead Body" bill enacted during the '70 legislature was written with a view toward increasing the availability of cadavers for use in medical and dental schools in Georgia.

Under existing Federal law the Social Security Administration and Railroad Retirement Board will pay to the next-of-kin a stated amount of money for burial purposes. Claims arising under this statute have resulted in an inadequate supply of dead bodies for the medical and dental schools.

The purpose of the Georgia "Dead Body" bill is to make possible a payment to claimants of an amount equal to that paid by Social Security and Railroad Retirement. In return, the claimant would forego his claim and the body could then be delivered to the Board for subsequent transfer to the medical and dental schools of the State.

COMPOSITE MEDICAL-OSTEOPATHIC EXAMINING BOARD: H.B. 655, carried over from the 1969 session of the General Assembly, will create a Composite Board of Examiners for medicine and osteopathy. This bill as enacted contained numerous amendments as set forth by the MAG House of Delegates in 1969.

Among the more important provisions of the bill, as enacted, is that the Joint Board of Medical Examiners would be given the right to enjoin anyone engaged in the illegal practice of medicine; a right not enjoyed by the Board prior to the passage of this bill. In addition it specified July, 1963, as the cut-off date for the issuance of a license by reciprocity to an osteopath seeking full practice privileges in Georgia.

Further, the bill provides that the Board of Medical Examiners shall inspect or evaluate the good standing of all medical and osteopathic schools not previously approved. The same requirement would apply to internship programs for both disciplines.

CLINICAL LABORATORIES: This bill, S.B. 387, the end product of a Joint Interim Study Committee of the House and Senate (extensive hearings were held in numerous parts of Georgia during 1969) accomplishes three principal objectives. First it would license all laboratories except those operated in licensed hospitals, by the United States government or State government, for the purpose of teaching or research, or operated in the offices of physicians exclusively for the benefit of their own patients. Secondly, it provides that a physician must serve as the Director of the laboratory (with a "grandfather amendment" explained in next paragraph); and thirdly, it licenses Directors and Supervisors of laboratories.

Regarding the provision concerning M.D. Directorship, the bill was amended to provide that its terms would not apply to anyone serving as a Director or Supervisor as of the effective date of the Act. An additional provision of the bill relating to the same matter specifies that the Board of Health may promulgate regulations which authorize persons possessing doctorate degrees in biology, microbiology and related fields to be Directors of clinical laboratories when the proper circumstances and qualifications are present.

Broad regulatory powers for the implementation of the Act are given to the Board of Health.

VENEREAL DISEASE AND DRUG ABUSE: In 1969 the General Assembly enacted a bill to permit a physician to treat a minor for venereal disease without parental consent. This bill was later vetoed by the Governor.

The 1970 General Assembly enacted an identical bill, except it added the matter of drug abuse.

CHIROPRACTIC: As was the case in 1969, the chiropractors introduced bills in the 1970 Legislature (three in total—two in the Senate and one in the House) to require State Health Department inclusion of chiropractic services under the Title XIX, Medicaid program; and a separate measure to compel insurance companies to cover their services with all policy holders. Each of these bills was defeated in Committee with strong objections raised by MAG and spokesmen for the insurance industry as well as representatives of groups concerned with Workmen's Compensation.

It is significant to note that on the next to the last day of the session the Capitol literally swarmed with chiropractors (estimated to be approximately 100 in number) whose essential message to any legislator they could "button-hole" was that they were beginning their 1971 effort for enactment of these two bills early—during 1970, an election year.

In addition to these bills, MAG followed with great interest legislative proposals in the following fields: psychiatric insurance; hearing aid dispensers; preschool vision examinations; a host of traffic safety bills; expansion of abortion legislation; fluoridation; physical therapy; medical consent; environmental control; psychology; 18-year-old blood donors; and excise tax legislation which, had it passed, would have been the source of "bricks and mortar" money for an expanded Atlanta convention facility, thus increasing Georgia's chances of obtaining AMA conventions in the future.

"CROSSING THE BAR" AT THE INTENSIVE CARE UNIT

(As Tennyson would write it today)

*Sunset and evening star
And one clear "code" for me
May there be no pounding on the chest
When I put out to sea.*

*When the time shall come when I seem fast asleep
Now free from froth and foam
To those who by my bedside vigil keep
Let me go "home."*

*Twilight and evening bell
And after that the dark
Don't bring me back to shore with counter-shock
When I embark.*

*And though I am borne to the 4th Floor, South
Don't carry things too far
Do your duty, my pretty, mouth-to-mouth
Then let me cross the bar.*

John F. Stegeman, M.D.

Ec- on- omy!

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ARCH LABORATORIES
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A FOND FAREWELL

THIS IS THE LAST ISSUE of the *MAG Journal* in which the picture above and the signature below will grace this page, as it is off with the old and on with the new. The now president-elect will take over next month and spread his thoughts here.

In my first letter, I mentioned that there would be no effort by me to bring a message, but rather the page would be filled with plagiarism, mostly from information dug out of many sources by my research department, my ever-luv'vin wife. So it has been. My desk drawers are filled with clippings, articles of interest, etc., about which I would like to write: i.e., the mental health situation and facilities in Georgia; the pollution of our air, water and people; the need for expanding our teaching facilities for medical and paramedical personnel; AMPAC and GAMPAC and many other items of interest, but my uninventive mind cannot compact some of the data to a page-and-a-half, double-spaced, and cannot condense some of the others to the same size. So-o-o. . . .

I am not one to decry the present state of the world nor to prognosticate that the existing order is to be completely overturned, nor to say that the end of the world is in sight. However, it is changing, and we have to do what we can to see that the changes are to the best interest of our patients. When the changes are not what we want at the time, we must roll with the punch and work for betterment in the future. We must go on doing what we are trained to do—deliver medical care to the people. St. Francis of Assisi was once asked, as he was working in his garden, what he would do if he were suddenly to learn that the world would come to an end at sunset. His answer was, "I would finish hoeing my garden."

We should go on doing our thing, treating the sick, delivering health care. Of course, St. Francis did not have many of the trials and tribulations that beset the gardener or grower or deliverer of anything of today, as shown in the tale of the ant and the grasshopper. Once there was an ant who worked hard all day in the fields; during the summer he was busy cutting grass and dragging it home. The ant had a grasshopper for a neighbor. The grasshopper sat in his doorway singing all day. When winter came, the ant had a whole bale of grass, but he had violated the law for over-harvesting grass. He was fined \$162.50 and the surplus was seized. The grasshopper received the surplus in exchange for his food stamps.

Such devotion to duty as St. Francis showed, and such industry as the ant showed, is like unto what Sir William Osler described in his essay "Aequanimitas"—"coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril. . . ."

This "Aequanimitas" we must show in our dealings with the members of our society and profession, in improving the delivery of health care, and in our deal-

ings with those in government positions who are more and more regulating same, even though we think, at the time, that they are ending our world or taking away our grass.

It has been a pleasure and a privilege to have been President of the Medical Association of Georgia, an honor I never thought would come my way. In a society based on the work of committees, this job would be unthinkable, untenable, unbearable and impossible, so I take this opportunity to extend my thanks to all those who have labored for MAG these past 12 months. Of course, without the help, advice, assistance, aid and forbearance of all the staff at the headquarters office, we might as well close down the Association. To them, all sorts of thanks for all their help.



John Kirk Train, M.D.
President, Medical Association of Georgia

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ASHEVILLE, NORTH CAROLINA

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A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

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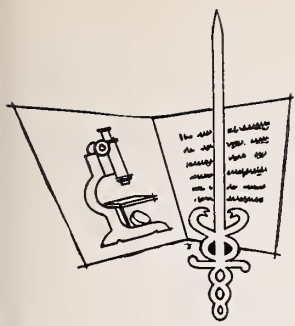
Contact: (1) Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry
and Medical Director

Area Code 704-254-3201



TUMORS OF MINOR SALIVARY GLAND ORIGIN

CHARLES A. WALDRON, D.D.S., M.S.D., *Atlanta*

EPITHELIAL TUMORS arising in the minor salivary glands comprise an interesting and challenging group of neoplasms. Although these tumors do not constitute a numerically large proportion of the human cancer problem, their superficial location and relative ease of adequate treatment in the early stages permits good control.

The minor or accessory salivary glands are primarily mucous in type and are located throughout the oral cavity with the exception of the gingiva and the anterior hard palate. The largest concentration of these glands is found on the posterior portion of the hard palate and soft palate.

A number of detailed and complex classifications for salivary gland tumors have been suggested. The simplest include adenomas, benign mixed tumors (pleomorphic adenomas) and a variety of carcinomas. The parotid gland is the most frequent site of salivary gland tumors, and a majority of these tumors are benign. Several large series, including up to 1,000 cases, have shown that about 70 to 80 per cent of parotid tumors are benign. On the other hand, minor salivary gland tumors are some what more likely to be malignant than benign. In 40 cases in the files of the department of pathology, Emory University School of Dentistry, benign and malignant types were seen with about equal frequency.

Although minor salivary gland tumors may arise almost anywhere in the upper respiratory and gastrointestinal tracts, about half of them are found on the posterior hard palate and soft palate. A submucosal mass or lump in this location should be considered to be a salivary gland tumor until proven otherwise. These tumors may occur over a wide range and a significant number are seen in the 3rd and 4th decades. Both major and minor salivary gland tumors show a rather marked predilection to occur in females.

Minor Tumors

Minor salivary gland tumors usually present as a firm, painless submucosal mass or nodule. The patient is often unaware of the lesion, particularly if the lesion is small. Clinical differentiation of benign from malignant forms is difficult if not impossible unless the lesion is quite large. Ulceration of the covering mucosa is a relatively late finding and while this is usually associated with malignant salivary gland tumors, it may occur with the benign lesion. Palatal salivary gland tumors can quite easily be differentiated from the common midline exostosis (torus palatinus). This lesion is always in the midline of the palate and is bony hard on pal-

pation. Minor salivary gland tumors in other locations are frequently confused with mucous retention cysts and fibromas. Unless the suspected salivary gland tumor is quite small and can be adequately excised as an excisional biopsy, a well-planned incisional biopsy is indicated. This permits the surgeon to plan the adequate operation for the type of tumor in question.

Surgical excision is the treatment of choice for minor salivary gland tumors. Benign mixed tumors respond well to conservative local excision and the reported recurrence rate is practically nil. The various types of malignant salivary tumors of the minor glands require more extensive excision although there is some honest debate as to the extent of surgery required for the various types of tumors. Fortunately most salivary gland carcinomas are of relatively low grade malignancy. This is particularly true for the well-differentiated mucoepidermoid carcinoma where long-term survival rates of over 90 per cent are commonly reported. Adenoid cystic carcinomas, on the other hand, have a rather poor long-term prognosis. This tumor is a classic example of a "wolf in sheep's clothing." It may appear deceptively benign on clinical and even microscopic examination. This tumor, however, is very prone to distant and late metastasis.

Emory University School of Dentistry

Yes, to fear something and not have it—that frequently seems to have more serious effects upon the patient than having the condition itself. So why not tell the patient the truth if he wants to know it.

—William Sharpe

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, MARCH 14, 1970

Letter to all members regarding third party carrier cooperation: The Executive Committee thoroughly reviewed and amended a proposed letter to all members of MAG regarding cooperation with third party carriers, prepared by the Committee on Medical Review and Negotiating. The Executive Committee then endorsed the letter and decided to ask the Editor to consider publishing it in the *Journal-MAG*.

MAG Foundation, Inc.: The Executive Committee learned with regret that Mr. Mills B. Lane, Jr., would be unable to serve as a trustee of the MAG Foundation, Inc., and decided to ask Mr. Everett Williams, of Statesboro to serve.

Liaison Committee with the Georgia State Medical Association: The Executive Committee approved appointments by President John Kirk Train to the Liaison Committee with the Georgia State Medical Association as follows: Mason Robertson, M.D., Savannah, Chairman; G. A. Johnston, M.D., Macon; William Logan, M.D., Atlanta; and Glen Garrison, M.D., Augusta.

News media liaison: The Executive Committee discussed publicity attendant to recent publication of reports on Government third party programs and the implication of abuse of those programs by the medical profession. The Committee then agreed that representatives of the news media should be invited to attend a meeting of the Committee on Medical Review and Negotiating for a first-hand view of MAG's efforts to assist those programs through peer review.

AMA Meetings: It was reported that MAG had withdrawn its invitation to AMA to hold its 1972 Clinical meeting in Atlanta, and in its place, had invited them to hold the 1977 Clinical meeting here. The Committee then agreed that on completion of the Civic Center expansion, the AMA should be invited to consider Atlanta as the site for an Annual Session.

April Meeting: The Committee then set its next meeting for 10:00 a.m., Saturday, April 11, at MAG Headquarters, Atlanta.



PULMONARY EMBOLISM AND THE UROKINASE PULMONARY EMBOLISM TRIAL

NANETTE KASS WENGER, M.D., *Atlanta*

PULMONARY EMBOLISM is a major cause of hospital deaths; it is the most common acute pulmonary disease in most general hospitals. Pulmonary embolism is encountered most frequently among cardiac patients, in post-operative patients, and in aged and debilitated persons; its increased incidence among women taking oral contraceptive agents remains controversial. Accurate early recognition and prompt effective treatment are imperative in pulmonary embolism.

The symptoms and physical findings of pulmonary embolism are extremely variable. Small pulmonary emboli may be clinically evident only as periodic breathlessness and tachycardia. Larger pulmonary emboli may result in the symptom complex of pulmonary infarction: tachycardia, fever, dyspnea, pleuritic pain, hemoptysis, etc.; or of acute cor pulmonale: tachypnea, tachycardia, pulmonary hypertension, systemic hypotension, cardiac arrhythmias, cardiac failure, and hypoxemia. Less frequently, massive pulmonary embolization may produce sudden death. The patient with recurrent pulmonary emboli, with and without infarction, presents the clinical picture of chronic cor pulmonale.

The conventional therapy for pulmonary embolic disease, heparin and orally administered anticoagulant drugs, is designed to prevent new clot formation and to inhibit the extension of a thrombus, with recurrent embolization. The surgical procedures, femoral vein and inferior vena cava ligation, also have the rationale of preventing recurrent embolization to the lung. Rarely, pulmonary embolectomy is required to physically remove massive, life-threatening pulmonary emboli. There is currently no conventional medical means of altering or lysing existing intravascular thrombi or emboli.

A more rational approach to the management of pulmonary embolic disease is the use of a thrombolytic (fibrinolytic) agent to enhance and accelerate the normal thrombolytic mechanisms of the body; urokinase and streptokinase, both plasminogen activators, are two such agents. Cardiologists at the Emory University School of Medicine are currently involved in a national cooperative clinical trial to evaluate the therapeutic efficacy of urokinase in the treatment of acute pulmonary thromboembolism.

Urokinase, a non-antigenic, non-pyrogenic, minimally toxic thrombolytic agent derived from human urine, has been shown to produce a reasonably predictable

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

and reproducible thrombolytic state in man. The thrombolytic activity mediated by urokinase administration is dose-related. The accelerated thrombolysis caused by urokinase has effected the dissolution of experimentally and naturally-occurring intravascular clots in animals and in man. Preliminary clinical and laboratory observations suggest that lysis of thromboemboli is considerably accelerated by the administration of urokinase. The urokinase infusion has been well tolerated, even by severely ill patients, in an adequate number of these preliminary observations; the only toxic effects were those related to an enhanced thrombolytic state, oozing and bleeding.

Acute pulmonary embolism affords an ideal investigational model to evaluate the efficacy of thrombolytic agents because:

1. It is a common clinical condition associated with significant morbidity and mortality.
2. The embolus to the pulmonary vascular bed may often be a clot of recent origin, having fibrin as its major constituent.
3. Adequate blood flow to the area of the clot assures a satisfactory concentration of the thrombolytic agent.
4. The pulmonary blood vessel at the area of clot lodgment is usually without significant disease.
5. Objective measurements are available to assess clot resolution: serial hemodynamic measurements, pulmonary angiograms, and lung scans.
6. The drug-induced thrombolysis can be compared with known information about spontaneous clot resolution.

The Urokinase-Pulmonary Embolism Trial is designed to quantitate the morbidity and mortality of patients with pulmonary embolism and to compare the resolution rate of these emboli in patients treated with urokinase infusion followed by parenteral heparin as compared with the conventional therapy, heparin alone. Patients with the clinical diagnosis of acute pulmonary thromboembolism occurring within five days of inclusion in the Urokinase-Pulmonary Embolism Trial must have substantiation of this diagnosis by standard criteria for abnormalities on the lung scan and pulmonary angiogram. If no clinical or laboratory contraindications to thrombolytic therapy are present, these patients are, after appropriate informed consent, randomized into a "modified double-blind" protocol. Resolution rate of the pulmonary emboli is documented by a post-therapy pulmonary angiogram and serial lung scans for two weeks.

It is expected that the data from this clinical trial will both augment our knowledge of the natural history of acute pulmonary thromboembolic disease as treated by conventional therapy, and will evaluate the efficacy of thrombolytic therapy with urokinase in acute pulmonary thromboembolic disease.

*Emory University
School of Medicine*

Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible.

—Sir William Osler



"1970 GEORGIA STATUTES"

JOHN L. MOORE, JR., *Atlanta**

THE GENERAL ASSEMBLY OF GEORGIA, in its 1970 Session, adopted several statutes of general interest to Georgia physicians.

New Professional Association Act

Senate Bill 389 substantially rewrites the Georgia Professional Association Act, originally passed in 1961. Senate Bill 389 provides that the Georgia Business Corporation Code applies unless the context of the Professional Association Chapter otherwise requires, to professional associations or professional corporations as the new Bill mainly calls them. The most important change in the Act is the provision that a professional corporation may be formed by a single person as well as by a group of persons practicing the same profession. Senate Bill 389 will become effective immediately upon approval by the Governor or its otherwise becoming law. It is important for those already practicing as a professional association to know that they must take affirmative steps within 120 days of the effective date of the new statute to apply to the Secretary of State of the State of Georgia for protection of the existing name of the professional association. Except for that provision, professional associations organized under present Chapter 84-43 of the Code of Georgia do not have to take any steps because of the enactment of the new statute unless the professional association chooses to elect to become subject to its provisions.

Treatment of Minors

Senate Bill 482 re-enacts the consent bill for the treatment of minors for venereal disease passed in 1969 and vetoed by Governor Maddox. At the same time Senate Bill 482 adds to its provisions the treatment for drug abuse. A physician may treat a minor who is or professes to be afflicted with a venereal disease, or is or professes to be suffering from drug abuse, with only the consent of that minor, provided the treatment afforded only involves procedures and therapies related to conditions or illnesses arising out of the venereal disease or drug abuse. In addition, the statute allows, but does not require, the physician to advise the spouse, parent, custodian, or guardian of the minor as to the treatment given or needed. This information may be given over the express refusal of the minor patient to the providing of such information. The statute also protects other persons on the treatment team and any hospital or public clinic in which the minor is treated.

Sterilization

The Georgia General Assembly has finally broadened the earlier Sterilization Act to cover, to some degree, mentally incompetent persons. The Eugenic

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

Sterilization statute is repealed in its entirety. House Bill 255 allows a physician to perform a sterilization procedure when acting in consultation with at least one other physician upon request by an adult person, provided the person's spouse consents if there is a spouse and if the spouse can be found after reasonable effort. With reference to incompetents, whether or not minors, there must be a proceeding in the Court of Ordinary. After the filing of the petition by the parents, guardian, next-of-kin or certain state or county officials, accompanied by the written consent of the parent or parents or guardian, the Court of Ordinary appoints two physicians to investigate and report to the court. The physicians must report that they have examined the person alleged to be incompetent and that they find that such person is irreversibly and incurably incompetent to the degree that such person, with or without economic aid (charitable or otherwise) from others, could not provide care and support for one or more children procreated by such person in such a way that such children could reasonably be expected to survive to the age of 21 years without sustaining serious mental or physical harm. Evidence must also be given to the Court of Ordinary that a committee especially established in the hospital in which the procedure is to be performed has, by a majority vote of a membership of not less than three members of the hospital staff, made the same finding as the two physicians above mentioned. The Ordinary then must make the same findings on a legal preponderance of all the evidence. Full provisions for appeal and the right to counsel are contained in the Act. The sterilization procedure must be one designed to prevent conception but not designed or intended to unsex the patient by removing the ovaries or testicles. The procedure must be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals. The Act specifically provides, in the same fashion as the recent abortion statute, that no individual, hospital, or professional person needs to be associated in any way with the performance of sterilization procedures or committee procedures under the Act if they object thereto on moral or religious grounds. The statute also provides that physicians acting pursuant to the Act are not liable civilly or criminally for participating in the procedure except in the case of malpractice.

Licensing of Clinical Laboratories

Senate Bill 387 provides for the licensure of certain clinical laboratories. A wide number of such laboratories are exempt: those operated by the United States Government; those operated for research and teaching purposes involving no patient or public health services; those performing solely premarital serologic tests for syphilis; laboratories in hospitals subject to licensure by the Department of Health; laboratories operated by physicians exclusively in connection with the diagnosis and treatment of their own patients; and laboratories licensed already by the United States Government. The State Board of Health has been given broad powers to promulgate rules and regulations for the standards of buildings, procedures, and educational background of the director and supervisors. The Act also provides for the licensing of directors and states that directors (except for those who are directors on the effective date of the Act) must be either licensed physicians or those possessing doctorate degrees in biology, microbiology, and related fields under rules and regulations to be prescribed by the State Board of Health. It appears to this writer that there will have to be court construction of the meaning of the grandfather clause which states simply that nothing in the Act shall be construed to affect any director, supervisor, technologist or technician who is holding any such position on the effective date of the Act.

*Suite 1220
C & S Bank Building*

OPEN LETTER TO MAG MEMBERS

Dear Fellow Member:

Your Executive Committee of Council has seen fit to appoint me to the Chairmanship of the MAG Committee on Medical Review and Negotiating, and I have accepted out of a sense of responsibility to serve my chosen profession. This Chairmanship has brought me into contact with the directors of all third-party agencies in the State, both governmental and private. I have found in every case that these directors of Georgia carriers are most anxious to see that their programs function within the implementing legislation, that our patients' medical needs are met, and that we, as providers, are justly compensated for the care we render.

At the present time, almost all third-parties in Georgia recognize the concept of usual and customary fees, though Medicare, Medicaid and CHAMPUS payments to you are frozen by Federal government regulations at a percentile of your charges as of January 1, 1969. These controls apply nationwide, and I am sure that as soon as those ceilings are lifted, July 1, 1970, increases will be forthcoming based on your charges being submitted now. *For this reason your usual charge should be rendered even if you have increased your fees and they cannot be paid in full.*

During this period of cost adjustment your Committee on Medical Review and Negotiating has enlisted the support of the Executive Committee, and we jointly urge you to lend your assistance to the success of those programs in our State this year. Patients' complaints under Medicare are adjudicated by a Fair Hearing, with the Hearing Officer appointed by the Carrier not necessarily being a physician. We sincerely hope to avoid such complaints. The U. S. Senate Finance Committee Staff Report that is now being distributed will create much adverse comment in the news media. However, through our Committee contacts, our claims review service, and through your attitude toward those programs, we will influence them to be another valuable tool in the delivery of medical services to Georgians. I covet your support.

With sincere thanks and best wishes,

Cordially,
John R. McCain, M.D., Chairman
MAG Committee on Medical Review
and Negotiating

THE ASSOCIATION



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Brightwell, Larry E. Active—Muscogee—Su	4313 Kennesaw Drive Columbus, Georgia 31907
Bruckner, Evert A. Active—Fulton—I	1365 Clifton Road, N.E. Atlanta, Georgia 30322
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Castillo, Reuben Active—Southwest Ga.—GP	P.O. Box Box 385 Edison, Georgia 31746
Crane, Paul S. Service—Fulton—Su	P.O. Box 29457 Atlanta, Georgia 30329
Creech, Earl L. Active—South Ga.—Or	7102 N. Forrest St. Valdosta, Georgia 31601
Gullen, Warren H. Active—Richmond—E	Medical College of Georgia Augusta, Georgia 30902
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Milledgeville, Georgia
31061

Sheppeck, Michael L.
Active—Baldwin—Adm.

Central State Hospital
Milledgeville, Georgia
31061

Skelton, W. Douglas
Active—Fulton—P

1365 Clifton Road, N.E.
Atlanta, Georgia 30322

Webster, Paul D., III
Active—Richmond—Ge

Medical College of Georgia
Augusta, Georgia 30902

SOCIETIES

The **Muscogee County Medical Society** had Dr. Thomas Y. Whitley, president of Columbus College, as their guest speaker at their February meeting. Dr. Whitley spoke on Columbus College's plans for an "allied health program."

Whitfield County Medical Society installed their officers for 1970 at their February meeting. The new officers are as follows: President, Paul E. Henson, Jr.; Vice President, Paul L. Bradley, and Secretary-Treasurer, R. T. Farrow.

PERSONALS

Fourth District

Catherine E. Foster, past president of the DeKalb County Medical Society, received a plaque from the Society at their February meeting, in appreciation for her year as president of that organization. Dr. Foster was the first woman to assume that office and is one of the few women in medicine in the country to be elected to such an office.

Tim Harden, Jr., was installed as President of the DeKalb County Medical Society in February.

Fifth District

Joseph Hertell received the Aven Citizenship Award from the Fulton County Medical Society in February. The award is for the physician making the most outstanding contribution to Atlanta.

John R. Lewis, Jr., president of the American Society for Aesthetic Plastic Surgery, and his wife entertained visitors attending the annual meeting of the Society at a cocktail buffet in their home in February.

Angvald Vickoren has been appointed director of the Georgia Branch of Licensure and Certification.

W. A. Selman was honored in February on his 95th birthday by fellow doctors, friends and family, for his 60-year surgical career.

Gerald F. Fletcher has been granted a Fellowship in the American College of Cardiology.

Sixth District

Thomas C. Graham was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting April 12-18, in New York City.

James J. Thomasson, Jr., has been inducted as a Fellow of the American College of Surgeons.

Seventh District

John J. Allen, formerly of Summerville, has joined the staff of Hamilton Memorial Hospital in Dalton.

Carl C. Aven has been reappointed to head the Senior Citizens Committee for the Republican Party of Georgia.

Jack L. Crews attended a five-day symposium entitled "The Physician and Intensive Coronary Care" in Nashville in February.

Ninth District

Allen Addison was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting April 12-18, in New York City.

DEATHS

Cecil D. Cason

Cecil D. Cason died February 6 at Memorial Hospital in Waycross from injuries sustained in a January 31 automobile accident. He was 34.

Dr. Cason received his B.S. degree from the University of Georgia and his medical degree from the Medical College of Georgia. He served an internship of one year at the Duval Medical Center in Jacksonville, Florida.

He was a member of the Alpha Epsilon Delta National Honorary pre-medical fraternity, and the Alpha Kappa Kappa fraternity. He was a member of the Rehobeth Baptist Church.

Dr. Cason began his practice in Waycross in 1963 after serving as a general medical doctor in the U.S. Air Force in Florida.

He is the best physician who is the best inspirer of hope.

—Samuel Taylor Coleridge

Survivors include his mother, Mrs. Quitman L. Cason of Waycross; two sisters, Mrs. Alvin Sweat and Mrs. James F. Bennett, both of Waycross.

Ira A. Ferguson

Ira A. Ferguson, former chief of surgery at Grady Memorial Hospital in Atlanta, died February 26 at the age of 74.

Dr. Ferguson was chief of surgery at Grady for 17 years following World War II and also was a clinical professor of surgery at Emory University School of Medicine.

Born in Anniston, Alabama, he was graduated from the University of Alabama and Emory University School of Medicine. He served his internship and residency at Emory and Grady hospitals.

Dr. Ferguson was a member of the American Medical Association, the Fulton County Medical Society, Medical Association of Georgia, Southern Surgical Association, Southeastern Surgical Association, Southern Medical Association, Georgia Surgical Society, Southern Surgeons Excelsior Society and the Society of Medical Consultants to the Armed Forces.

He also was a member of the Capital City Club and St. Michael and All Angels Episcopal Church in Anniston.

Survivors include his widow, two sons, a sister and two brothers.

George Sassos

George Sassos died February 4 in Ware Memorial Hospital, Waycross, of an apparent heart attack. He was 46.

Dr. Sassos was a native of Donora, Pennsylvania, and was a graduate of the Medical College of Columbus, Ohio. He had further residency training in surgery at Cleveland, Athens, Greece, and Berlin, Germany.

He was a veteran of World War II and attended the Vidalia Episcopal Church. Survivors include his widow, Mrs. Elly H. Theodore Sassos; a son, Phillip, and a daughter, Vasilla, all of Vidalia; three brothers, Jim and John Sassos of Cleveland, and Sax Sassos of Canton, Ohio; and a sister, Mrs. Chris Anne Stoweianos, of Canton, Ohio.

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Contents

Scientific Articles

DISTRIBUTION OF PHYSICIANS RENDERING PEDIATRIC CARE IN GEORGIA	
J. Rhodes Haverty, M.D.	169
A STUDY OF PHYSICIANS' ATTITUDES CONCERNING GENERIC PRESCRIBING	
Charles L. Braucher, Ph.D., and Albert W. Jowdy, Ph.D.	175
NON-CONTRACEPTIVE USE OF PROGESTINS	
Paul G. McDonough, M.D., F.A.C.O.G., and David Cardosa, M.D.	181

Special Report

REPORT OF THE SUBCOMMITTEE FOR PERINATAL MORTALITY AND MORBIDITY	
Malcolm G. Freeman, M.D.	173

Clinical Note

THE VALUE OF BRONCHIAL WASHING CYTOLOGY IN THE DIAGNOSIS OF BRONCHOGENIC CANCER	
Ronald F. Galloway, M.D.	180

Editorials

1970 AMA ANNUAL CONVENTION	188
WHY A WOMAN'S AUXILIARY?	
Mrs. S. William Clark, Jr.	188

Features

President's Letter	190
Cancer Page	192
Heart Page	194
Calendar	187

The Association

New Members	196
Societies	196
Personals	197
Deaths	197

Cover

Young people from all social, economic and cultural levels are "turning on" to drugs every day. The epidemic is by no means limited to hippie communities, as the many excellent articles in lay and professional publications point out. Our models are not using drugs, but cooperated with UPI photographer Tim Murphy to help our membership to a greater awareness of the problem. Layout by Marie Seaman.

Distribution of Physicians Rendering Pediatric Care in Georgia

J. RHODES HAVERTY, M.D., *Atlanta*

A STUDY WAS UNDERTAKEN to ascertain the relative distribution of physicians who take care of children in Georgia. Our state has about four-and-a-half million people, of whom about one-third are children between the ages of zero to 14. Of these slightly less than one-and-one-half million children, about one-third, or 500,000, are between the ages of zero to four. There are about 800 General Practitioners in our state, and about 325 Pediatricians and Pediatric residents, giving overall ratios of about 1-to-2,000 of General Practitioners and 1-to-4,000 of Pediatricians to all children between the ages of zero-to-14. In overall figures, these are not too far from adequate.

It was felt that the results of the study could be shown best by using maps relating the number of physicians to children by counties, on a state-wide basis, and by census tracts within the five-county metropolitan Atlanta area and within the city limits of Atlanta.

The maps were computer-generated on the RCA Spectra 70 at Georgia State University, employing the SYMAP program devised by the Laboratory for Computer Graphics of Harvard University. The study was made possible by the cooperation of the School of Allied Health Sciences; the Geography Department of the School of Arts and Sciences, with Malcolm A. Murray as chairman; the Urban Life Center, and the computer center, all of Georgia State University. My thanks and much credit must be given to Miss Julia Maddox, a student within the Geography Department at Georgia State, who did the better part of the work in putting this paper together.

Production System

The system of producing these SYMAP's involves

a process of digitizing the outline of areas to be mapped, geo-coding the location of data points, providing the data values (i.e., the ratio of physicians to population), then programming certain instructions relative to the type of map portrayal desired. In this case, we have employed a contour system of mapping.

It will be noticed that the white to black visual graduation from low densities of physicians, to high densities, is accomplished by a process of printing and overprinting of character symbols.

These maps, when analyzed, thus can tell a story about the accessibility to physicians who normally render child care for the children of Georgia, and of the Atlanta area.

The maps will be shown in pairs for each of the three geographic areas involved. Each pair will include the map for General Practitioners and for Pediatricians in the respective study. A "mind's eye" mixing together of the two maps will result in the total child care potentiality involved.

The age groups represented are from zero-to-14. These figures were obtained from the 1965 census estimates. The numbers of General Practitioners, Pediatricians, Interns, and Residents are 1969 actual figures. These data are reflected on a county-base for the state as a whole (159 counties), and on a census tract base for the Metropolitan area (179 tracts), and for the Atlanta city limits (106 tracts). All data are based on number of physicians per 1,000 population within the specific age group.

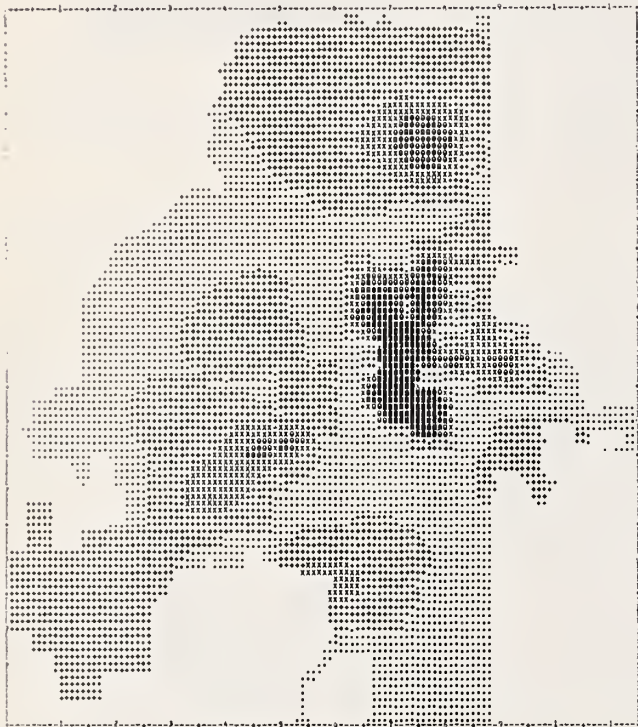
Atlanta Picture

Starting with the Atlanta city limits, the picture of General Practitioners and Pediatricians to the total child population is shown. It is well to note that of the 106 census tracts, 75 have no General Practitioners, and 90 have no Pediatricians.

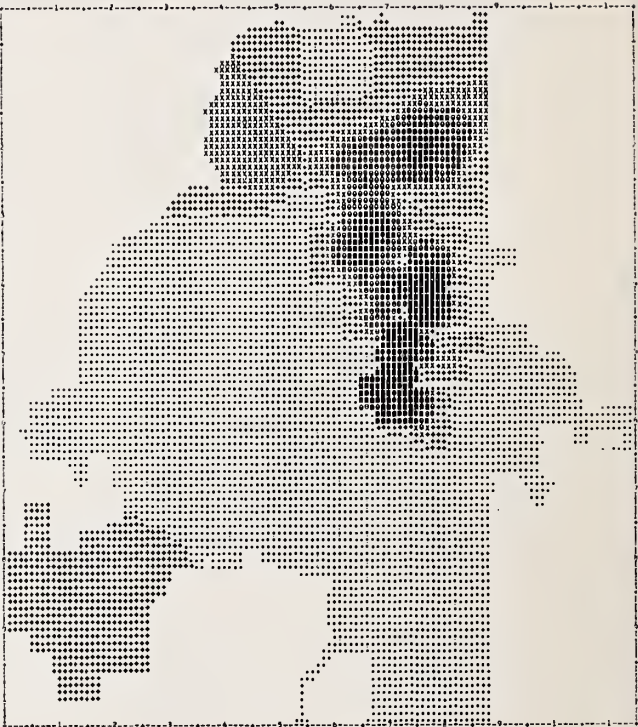
The relative preponderances of both types of

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	■	10.00 to 1000.00



Atlanta City Limits
Number of GP's per 1,000 of population in age group 0-14.



Atlanta City Limits
Number of Pediatricians per 1,000 of population in age group 0-14.

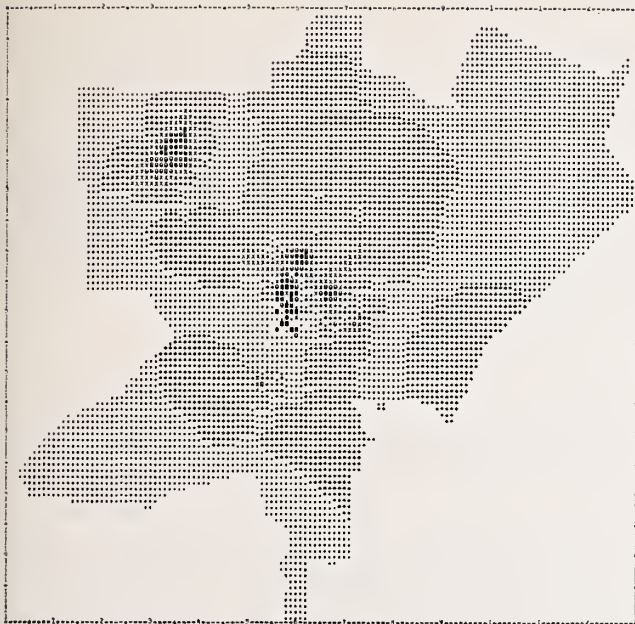
physicians in the general and northern portions of the city is evident, and the preponderance of the General Practitioners in the southwest portion of the city also is noticed in all the maps. The lightest areas (those with dots alone) represent no physicians practicing in those areas. The next darker area represents what might be considered adequate pediatric coverage. All denser areas than that represent higher-than-needed child care potentialities for children residing in that location.

Within the five-county Atlanta metropolitan area shown in the next pair of maps, there is a total child population of about 400,000 with about 200 General Practitioners and slightly less than 200 Pediatricians. Large areas are under-served, and of the 179 census tracts involved, 96 have no General Practitioners and 139 have no Pediatricians, some of which are the same census tracts, indicating no pediatric care indigenous to these areas.

State-Wide Pattern

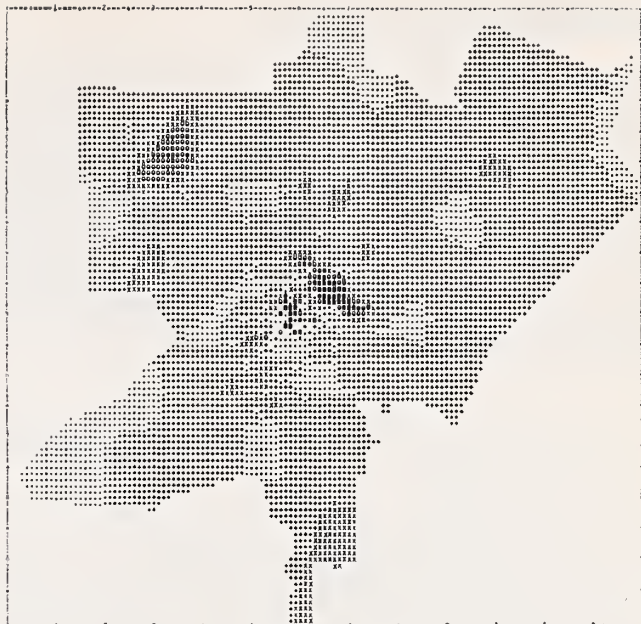
Moving on to the state-wide maps, some inter-

esting patterns are shown that were evident, though less so, in the other maps. Of our 159 counties in Georgia, 28 have no General Practitioners, and 121 have no Pediatricians. Unlike the Atlanta area census tracts, none of the counties which have no General Practitioners contain Pediatricians. Thus, in 28 counties in the state, there is no primary medical care for children. Much of this deficiency is in a fair-sized band of counties extending across the center of the state. Rather large areas also are scattered over the remainder of the state. Some of the densest areas are centered around Armed Forces bases within Georgia. Other dense areas in relatively sparsely populated portions of the state are unexplained. It should be noted that Interns and Pediatric residents have been added to the Pediatricians in computing these maps. This affects minimally the appearances of the counties of Fulton, DeKalb, Richmond, Muscogee, Bibb, Chatham, and Baldwin, the only counties in the state with Interns and Pediatric residents.



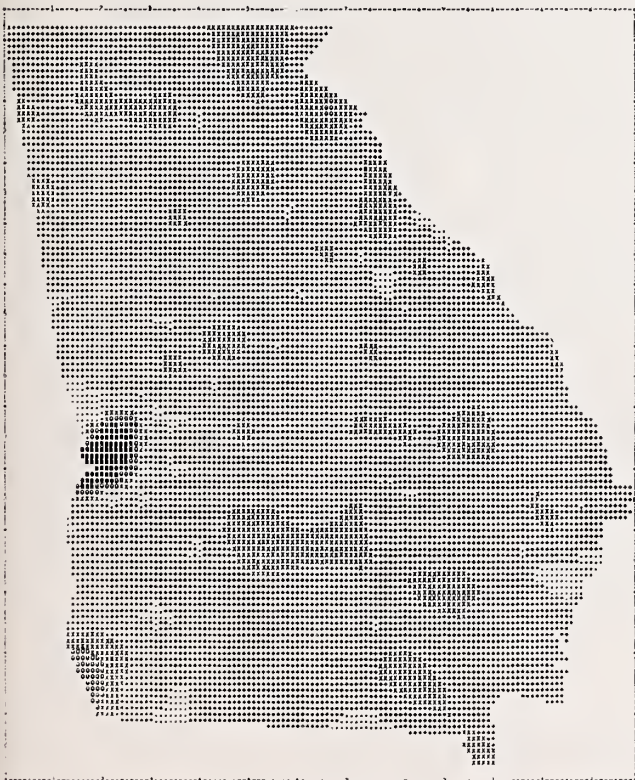
Metro Atlanta

Number of GP's per 1,000 of population in age group 0-14.



Metro Atlanta

Number of Pediatricians per 1,000 of population in age group 0-14.



State of Georgia

Number of GP's per 1,000 of population in age group 0-14.



State of Georgia

Number of Pediatricians per 1,000 of population in age group 0-14.

One additional group of data gleaned is interesting. In the *urban* areas of our state, the ratio of General Practitioners to total children averages about 1-to-2,000 with a range of from 1-to-1,500 to 1-to-2,500. The ratio of Pediatricians to total children averages about 1-to-2,500 with a range of from 1-to-750 to 1-to-6,000. In the *rural* areas

these ratios average 1-to-1,500 for General Practitioners and 1-to-15,000 for Pediatricians, with even wider ranges: obviously a marked difference in availability of excellence in infant and child care.

A few speculations concerning these facts are in order. To better serve our infant and child popula-

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tion in a more even fashion (to say nothing of equalizing the load of the physicians involved!), there would seem to be several alternatives possible. It must be realized, of course, that any of these alternatives creates more problems, and that the dilemma must be considered as a whole. Besides, possible *desirable* alternatives may not be achievable *practically*.

Alternatives

1. More Pediatricians and General Practitioners could be produced.
2. Existing Pediatricians and General Practitioners could be re-distributed geographically.
3. Present transportation routes and methods could be altered.
4. Other means of providing pediatric care could be utilized.

Alternative #1 already is being implemented in our state and nation. Medical schools are increasing their enrollments, and new medical schools are developing. With the installation of the twentieth specialty board by the AMA, that of Family Practice, it is anticipated that the recent continued decline in General Practitioners will reverse itself. Nevertheless, this alternative is the least satisfactory, since one can never hope to achieve adequate health care by attempting to increase the total number of physicians only.

Alternative #2 at first may seem impossible in a free country. Many incentives can be utilized both by federal and state governments to entice physicians into "deficit" areas. Local communities frequently provide benefits, which accrue to the physician and his patients, that are successful in bringing new medical manpower to these areas. One additional possibility involving this alternative could relate to the utilization of Armed Forces physicians in serving civilian needs. It has been noted in our

state that there is a more than adequate Pediatrician-General Practitioner population around military bases, but that these bases frequently are "islands" surrounded by counties or districts lacking in such adequate health care. Some mechanism by which these military physicians could be released to serve civilian needs, or else a lessening of the number of military physicians would seem to be logical possibilities.

Allied Health Personnel

Alternative #4, of course, involves the use of allied health personnel. This movement is already underway, both in the nation and in our state of Georgia. It is anticipated that such individuals as the Pediatric Assistants Program, presently developing at Georgia State University, will go far in alleviating some of the problems related to lack of pediatric care for our children. Other types of allied health personnel undoubtedly will be developed, and different combinations of existing types of allied health personnel will show new ways of providing care to the children of our state.

I would like to conclude with a bit of personal philosophy that relates to whatever solutions are attempted, and which I believe to be an important concern in the final outcome. The fee-for-service concept must continue for those physicians who care for the bulk of our children. Large numbers of physicians with the talent and dedication needed for the demands of the day-to-day private practice of medicine cannot be induced to undergo these rigors by salaries alone. However, a corollary to this point must be made: those *practicing* physicians will have to relinquish some of the prerogatives of planning *how* medical practice will evolve, to those who *are* salaried. It is only salaried individuals who have the time and lack of constant pressure to be able to reflect on, to plan for, and to promote what a changing society is demanding.

33 Gilmer Street, S.E.

THIRD ANNUAL COMMITTEE CONCLAVE

Marriott Motor Hotel

Atlanta, Georgia

AUGUST 15-16, 1970

Plan to Attend!

Report of the Subcommittee for Perinatal Mortality and Morbidity

MALCOLM G. FREEMAN, M.D., *Atlanta*

THE PERINATAL MORTALITY AND MORBIDITY Subcommittee of the Maternal and Infant Welfare Committee of the Medical Association of Georgia has been charged with the responsibility for suggesting ways in which perinatal mortality throughout our state can be studied and significantly reduced. In the October, 1968, issue of the *Journal of the Medical Association of Georgia*, the Perinatal Subcommittee offered a preliminary report of its activities. This report noted that the state of Georgia has moved from 48th place in total perinatal mortality between 1956 and 1960, to 45th place from 1961 to 1965.

It has been suggested that such gloomy figures may be a misrepresentation since a much larger percentage of our population is made up of high risk Negro women than are found in many non-Southern states. Slightly more than one-third of all deliveries in Georgia are among Negro patients. Perinatal mortality rates among Negro women may be twice as high as those of Caucasians.

We have examined the statistics for perinatal mortality by race for the same two five-year periods. Non-white perinatal mortality rates have improved. Georgia has dropped from 44th place among the states in non-white perinatal mortality to 34th place and, in the 1961-65 period for the first time Georgia fell below the national non-white perinatal mortality rate. White perinatal mortality rates are very close to the national average and put us in 34th place among the 50 states.

Fetal Death Rates

Georgia's worst showing is in fetal death rates where we rank 42nd among the states in white fetal death rate, and 44th in non-white fetal death rate, exceeded only by Alabama, Mississippi, North Carolina, Pennsylvania, South Carolina, and

Virginia. Our best showing is in neonatal mortality, in which we rank 20th among the states for both white and non-white patients. Georgia's white neonatal death rate is the same as the national average and the non-white neonatal death rate is considerably lower than the national average.

Such statistics as Georgia's neonatal death rates might be used to suggest that no special perinatal studies were necessary since both white and non-white babies born alive have a better chance of survival than the national average. This point of view is unacceptable. A low neonatal death rate coupled with an abnormally high fetal death rate simply means that the unborn babies at risk did not receive sufficiently adequate obstetric care to survive labor and delivery. In this case, the low neonatal death rate is, therefore, more indicative of how many babies in jeopardy died before birth than it is a measure of neonatal survival. It is more a measure of poor obstetric care than superb neonatal care.

Georgia is the largest state east of the Mississippi River. Within our boundaries there are wide differences in altitude, soil, climate, population, wealth, occupation, and industry. The patterns of living of our people vary from the most rural of the rural to the most urban of the urban. To study a problem as complex as perinatal mortality in a geographic area the size of the state of Georgia, it is relatively useless to consider the state as a whole. Perinatal mortality rates show striking variations from a maximum of 166/1000 (almost 17 per cent) of Negro births in Murray County for instance, to a rate of zero mortality for Caucasian births in Taliaferro and Webster Counties (1961-65). It is necessary to study obstetric problems by geographic areas and specific communities to identify specific and characteristic problems in each area. What may be a good solution for a care problem in DeKalb or Muscogee County may be poor advice in Grady or Toombs County. The problems of improving

Presented at the Annual Meeting of the Medical Association of Georgia, Savannah, May 5, 1969.

REPORT / Freeman

care in Habersham may be far different from the problems of Chatham.

Identifying Problems

To solve the task of identifying specific problems in localized geographic areas the Maternal and Infant Welfare Committee of the Medical Association of Georgia has recommended the adoption of a Supplementary Medical Report to become a part of the Live Birth and Fetal Death Certificates on each baby born in the state of Georgia. Such a report was, at one time, an integral part of Georgia's birth certificate. A Supplementary Medical Report is a part of the birth certificates used by 48 of the 50 states at the present time and is a part of the proposed birth certificate recommended by the Federal Government. Georgia and Massachusetts are the only two states who do not gather and analyze supplementary data concerning pregnancy, labor, and delivery. Our results are not so good that we can afford to be indifferent.

The information thus obtained is not reproduced on copies of the birth certificate supplied to the parents and is a confidential medical record for statistical and research purposes only. The analysis of data thus obtained ought to be part of the routine functions of the State Health Department and can be made available to qualified investigators from the Medical Association of Georgia and other groups that wish to study reproductive complications in the various regions of the state. Only by so doing, can we identify specific problems, improve the quality of reproductive care, and decrease our perinatal mortality rates.

Perinatal Mortality Committees

Approximately one and one-half years ago a questionnaire was sent out by the Perinatal Subcommittee to the 167 licensed Georgia hospitals which are listed as having bassinets to determine numbers of deliveries, stillbirths, and neonatal deaths, as well

as ascertain the presence of a perinatal death review committee. Replies were received from 70 hospitals or 42 per cent of those hospitals queried. Of the 67 hospitals accredited by the Joint Commission on Hospital Accreditation, 39 or approximately 60 per cent replied.

Among many hospitals there was something less than burning enthusiasm at the thought of organizing yet another committee. Most of the larger hospitals already had well-functioning perinatal mortality committees or more commonly were accomplishing this function by means of separate pediatric and obstetric staff meetings. Some of the medium- or small-sized hospitals were unable to determine from their records how many stillbirths and neonatal deaths had occurred over a two-year period. The questionnaire itself stimulated several hospitals to organize or reorganize perinatal committees. We hope to use this information to stimulate the formation of more committees and to find opportunities for committee leaders to meet and share experiences in a workshop setting.

In the final analysis, it will always be necessary for each medical community to analyze its own case load and medical complications including perinatal mortalities. The Perinatal Mortality and Morbidity Subcommittee hopes to be able to assist in the formation and efficient operation of local perinatal committees when asked. We would like to assist individual communities to make their perinatal committees a useful mechanism for review and self-improvement of medical care. The sheer volume of perinatal mortalities in this state makes it impossible to operate a state perinatal mortality committee in the same manner as the state maternal mortality committee with an individual review of each case. We believe that the Committee is far more likely to be productive by encouraging the formation of local perinatal mortality committees and by identifying within the state geographic areas which have specific and individual problems in the supply of quality reproductive care.

69 Butler Street, S.E.

**64th ANNUAL MEETING
Southern Medical Association
Dallas Memorial Auditorium
Dallas, Texas
NOVEMBER 16-19, 1970**

This paper is more correctly a study of physicians' opinions regarding generic prescribing.

A Study of Physicians' Attitudes Concerning Generic Prescribing

CHARLES L. BRAUCHER, Ph.D., and ALBERT W. JOWDY, Ph.D., Athens

THE PRESCRIPTION DRUG MARKET in the United States continues to increase by healthy margins. The 1968 Gosselin report on pharmaceutical marketing showed an 8.5 per cent increase in drug manufacturers' sales to community pharmacies and hospitals, an increase which the author described as phenomenal. Along with this increase, the same report indicated that 43 million prescriptions were written by generic name in 1968, a 25.6 per cent increase over the year before. This substantial gain, in turn, increased the "generics'" share of the total new prescription market to 8.2 per cent, compared with 7.1 per cent in 1967.¹

The increased activity in generic prescribing heightens speculation regarding the future course of this aspect of our drug marketing system. Opinions have been expressed on both sides of the generic-brand name issue. A strong pro-generic prescribing stand has recently been taken by Dr. John Adriani, chairman of the American Medical Association drug council, who, according to the "Weekly Pharmacy Reports," urged that all prescribing be done by generic name and "drugs be sold by generic names, just like . . . oatmeal."² An opposite view, which implies a price-quality dilemma has been advanced by Maj. Jordan D. Johnson, Jr., Chief of the Pharmacy Section, U.S. Air Force Medical Service School.

"The failures of drug products procured by use of the competitive bidding system used by the Federal government are all too familiar to military pharmacists. Because of these reoccurring failures, the drug procurement section of the Department of Defense has found it necessary to establish an analytical laboratory and to set up a factory inspection system to obtain some measure of quality assurance for the drugs they procure. Even this well-conceived program has not assured therapeutic

equivalency, although it admittedly goes farther than any existing civilian program. It follows that military procurement of drug products cannot be made on a strictly generic basis."³

The Task Force on Prescription Drugs of the U.S. Department of Health, Education, and Welfare, in its final report, recommended a course of action which fits somewhere between these two opposing views. "The Task Force finds, therefore, that the use of low-cost chemical equivalents can yield important savings . . . and the use of such products should be encouraged wherever this is consistent with high quality health care."⁴

The dialogue which has been building over the generic drug issue has, for the most part, ignored the attitudes of that sector of the drug distribution system which is generating the record-breaking drug volume referred to earlier—the practicing physician. This study, therefore, has as its objective the investigation of physicians' attitudes concerning generic prescribing.

Methodology

The study reported in this paper was conducted among 108 practicing physicians in the state of Georgia. A short-answer questionnaire was used to collect information by personal interview. Because of the choice of this technique and limited resources the resulting sample was not stratified geographically or by type of practice, nor was it selected randomly. The sample did, however, cover a wide geographical range within the state. A total of 16 medical specialties were represented in the study. Any conclusions drawn, therefore, must be viewed within the framework of these limiting factors.

The questionnaire used to gather the data listed nine medical specialties and general practice. Provisions were made for the physician to identify his specialty if it was not listed. The year in which the physician's M.D. degree was awarded was also recorded. The physician was asked to give

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TABLE 1 RESPONSE TO QUESTION "DO YOU FAVOR PRESCRIBING DRUGS BY THEIR GENERIC NAMES?," BY MEDICAL SPECIALTY					
Medical Specialty	Yes	No	Unde- cided	Total	Per Cent
Cardiology	2	1	1	4	3.7
Dermatology	1	0	0	1	0.9
E.N.T. (E.E.N.T.)	3	2	0	5	4.6
General Practice	9	19	0	28	25.9
Internal Medicine	5	2	1	8	7.4
OBGyn	3	7	0	10	9.3
Ophthalmology	1	1	0	2	1.9
Orthopedics	3	4	1	8	7.4
Pediatrics	2	3	1	6	5.6
Psychiatry	3	3	0	6	5.6
Surgery	13	7	0	20	18.5
Urology	0	2	0	2	1.9
Other Medical Specialties	3	4	0	7	6.5
Unspecified	1	0	0	1	0.8
Total	49	55	4	108	100.0
Per cent	45.4	50.9	3.7	100.0	

a "Yes" or "No" answer to the question, "Do you favor prescribing drugs by their generic names?" Those physicians who answered this question "Yes" were then asked to state the extent to which they prescribed generically (as a per cent of total prescribing). In addition, the same physician group, the "Yes" group, was asked to indicate the types of medications which they most frequently prescribed generically. The list of therapeutic types included antibiotics, analgesics, hormones, cough-cold preparations, ataraxics, sedative-hypnotics, cardiovascular preparations, sulfonamides, anti-obesity preparations, antispasmodics, and "others." All of the physicians in the survey were asked to indicate their reasons for prescribing, or not prescribing, generically. The reasons were listed as follows: cost, third-party payment programs, information gained from detailmen, personal beliefs about "cost profits" philosophy, and other reasons. Finally, the phy-

TABLE 1A RESPONSE OF PHYSICIANS SPECIFYING MEDICAL SPECIALTY AND ANSWERING "GENERIC PRESCRIBING" QUESTION BY GENERAL PRACTITIONER AND ALL OTHER SPECIALTIES					
Type Practice	Favoring Generic Prescribing No.	Per Cent	Not Favoring Generic Prescribing No.	Per Cent	Total No. Per Cent
General Practitioner ..	9	32.1	19	67.9	28 100.0
Specialist	39	52.0	36	48.0	75 100.0

sicians were asked to make a prediction regarding generic prescribing by indicating whether the trend will continue to increase, remain the same, or decrease in the future.

Of the 42 physicians who responded, the largest frequency, 38.1 per cent, indicated that from 90 to 100 per cent of their prescriptions were written generically. Exactly 50 per cent of the physicians who responded stated that 80 per cent or more of their prescriptions were written generically, and approximately 83 per cent said that 50 per cent or more of their prescriptions were generic.

Results

Considering all physicians reporting, a very slight majority, 50.9 per cent, stated that they did not favor prescribing drugs by their generic names, and 45.4 per cent stated that they favored generic prescribing. There were 3.7 per cent of the respondents who remained undecided. The physicians' responses by medical specialty to the generic prescribing question are shown in Table 1. General practitioners and surgeons made up the two largest groups in the sample, with those engaged in general practice tending not to favor generic prescribing and the surgeons tending to favor the use of generics. When the general practitioners are compared to the other medical specialties combined into one group, as

TABLE 2 RESPONSE TO QUESTION "DO YOU FAVOR PRESCRIBING DRUGS BY THEIR GENERIC NAMES?," BY YEAR OF GRADUATION FROM MEDICAL SCHOOL				
Date of M.D. Degree	No. Favoring Generic Prescribing	No. Not Favoring Generic Prescribing	No. Responding	Per Cent Favoring Generic-Prescribing
1920-29	1	3	4	25.0
1930-39	5	9	14	35.7
1940-49	12	15	27	44.4
1950-59	17	20	37	45.9
1960-69	10	6	16	62.5
Total	45	53	98	—

seen in Table 1A, approximately two-thirds (67.9 per cent) of the general practitioners do not favor generic prescribing while a slight majority (52.0 per cent) of the medical specialists favor generic prescribing. When the data was analyzed by a chi square test to measure the relationship between physicians' preferences for generic prescribing and their G.P.-specialist configuration, the level of probability was .10, which was not statistically significant.

Those physicians who replied that they favored prescribing generically were asked to indicate the extent of their generic prescribing. Their replies are tabulated by intervals of 10 per cent in Table 3.

TABLE 3 EXTENT OF GENERIC PRESCRIBING BY PHYSICIANS WHO FAVORED GENERIC PRESCRIBING		
Indicated Extent of Generic Prescribing by Percentage Intervals	No. Physicians Responding	Per Cent Responding
0- 9	0	0.0
10-19	3	7.1
20-29	2	4.8
30-39	1	2.4
40-49	1	2.4
50-59	8	19.0
60-69	2	4.8
70-79	4	9.5
80-89	5	11.9
90-100	16	38.1
Total	42	100.0

The types of medications most frequently prescribed generically by those physicians who said that they favored generic prescribing are shown in Table 4. Over 50 per cent of the physicians responding stated that they prescribed generic antibiotics, analgesics, and sedative-hypnotics most frequently. Generic antibiotics were favored by the

TABLE 4 TYPES OF MEDICATIONS MOST FREQUENTLY PRESCRIBED GENERICALLY BY PHYSICIANS FAVORING GENERIC PRESCRIBING		
Type of Medication	No. Physicians Prescribing	No. Physicians Responding
Antibiotics	42	85.7
Analgesics	27	55.1
Sedative-Hypnotics	25	51.0
Cardiovascular preps.	16	32.7
Sulfonamides	12	24.5
Hormones	11	22.4
Ataraxics	8	16.3
Antispasmodics	5	10.2
Cough-cold preps.	5	10.2
Anti-obesity preps.	2	4.1
Others	6	12.2

TABLE 5 REASONS FOR PRESCRIBING, OR NOT PRESCRIBING, GENERICALLY BY PER CENT OF TOTAL PHYSICIANS RESPONDING (N = 98)		
Reason	No. Physicians	Per Cent
Prescribe Generically Because of:		
Cost	49	50.0
Third party payment program	13	13.3
Information gained for detail man	2	2.0
Personal beliefs about "cost-profit" philosophy	10	10.2
Other reasons	10	10.2
Do Not Prescribe Generically Because of:		
Cost	3	3.1
Third party payment program	5	5.1
Information gained from detail man .	18	18.3
Personal beliefs about "cost- profit" philosophy	20	20.4
Other reasons	39	39.8

greatest number (85.7 per cent) of generic prescribers.

A total of 98 physicians checked or otherwise volunteered reasons for prescribing, or not prescribing, generically. Their reasons are shown as a percentage of the total physicians responding (98) in Table 5. Among the physicians who gave reasons for prescribing generically, drug cost was the most frequently cited reason (50 per cent). Among the physicians who gave reasons for not prescribing generically, the most frequently checked specific reason (20.4 per cent) was "personal beliefs about cost-profit philosophy." It should be noted, however, that the "other reasons" choice became an open-end question in that many of the physicians who responded in the "do not prescribe generically" category checked this choice and then volunteered reasons. The "other reasons" choice for not prescribing generically was checked by 39.8 per cent of the total physicians responding. Among the more frequent reasons cited for not writing generic prescriptions were quality of product, reliability of manufacturer, and reasons concerned with therapeutic equivalency.

The physicians' predictions about future trends toward generic prescribing are shown in Table 6. A sizeable majority (60.4 per cent) of the physicians responding to this question predicted that generic prescribing will continue to increase. Approximately one-half as many (31.3 per cent) predicted that generic prescribing activity would remain at the present level and 8.3 per cent saw a decline in generic prescribing as a future trend. The possibility of a relationship between the length of time a physician has held his M.D. degree and

TABLE 6		
PHYSICIANS' PREDICTIONS ABOUT FUTURE TRENDS TOWARD GENERIC PRESCRIBING		
Prediction	No. Physicians Predicting	Per Cent
Generic prescribing will continue to increase	58	60.4
Generic prescribing will remain about the same	30	31.3
Generic prescribing will decrease	8	8.3
Total	96	100.0

his outlook regarding generic prescribing was investigated. Table 6A shows how 95 physicians from the sample predict future trends toward generic prescribing with reference to the year of their graduation from medical school. When the data was collapsed to meet the requirements of a chi square test, the relationship between the physicians' predictions and the date of their M.D. degree was not significant.

TABLE 6A			
PREDICTION ABOUT FUTURE TRENDS TOWARD GENERIC PRESCRIBING BY YEAR OF GRADUATION FROM MEDICAL SCHOOL (N = 95)			
Date of M.D. Degree	Generic Prescribing Will:		
	Increase	Remain Same	Decrease
1920-29	1	3	0
1930-39	7	3	1
1940-49	15	10	3
1950-59	24	9	3
1960-69	11	5	1
Total	58	30	8

The response of many of the physicians who answered this questionnaire went beyond the answers requested on the printed form. Both groups of physicians, those favoring and those not favoring generic prescribing, indicated through informal notes on the questionnaire their concern for the quality of the drug they prescribe and the reliability of the manufacturer who produced it.

Discussion and Conclusions

This study, although formally described as "A Study of Physicians' Attitudes Concerning Generic Prescribing," is not a measurement of attitudes per se. It is more correctly a study of physicians' opinions regarding generic prescribing. The relationship between an attitude and opinion is close. "An individual's attitude toward something is his pre-

disposition to perform, perceive, think, and feel in relation to it."⁵ Opinions have been defined as "specific judgements on particular issues." Thus, attitudes are in turn reflected in opinions and an opinion is often the complex resultant of many attitudes.⁶ The authors feel that this interrelationship between the two concepts, as they pertain to the issue of generic prescribing, is so strong that one may be equated with the other with a minimal margin of error. The physicians participating in this study were asked only to pass judgement on the general concept of generic prescribing. In view of this, their judgements could freely relate to factors—such as economic, political, professional concern, etc.—which influence attitudes. This point might well be the objective of future investigation to prove or disprove the validity of the assumption.

Complex Issue

This study of physicians' attitudes toward generic prescribing indicate that the issue is complex with few, if any, statistically significant distinguishing characteristics. Evidence of this is seen in the 50 to 45 ratio of physicians who do not favor generic prescribing. Although the general practitioners did not favor generic prescribing by a sizeable majority, the specialists were almost evenly split on the issue. The correlation between the two groups and their attitudes toward generic prescribing was not statistically significant.

There is some evidence that those physicians who favor generic prescribing back up their position by writing for generics, as seen in the fact that 50 per cent of this group stated that 80 per cent or more of their prescriptions were written generically. The fact that this claim is at variance with the finding that only 8 to 9 per cent of all prescriptions are written generically may be due to variations in frequency of prescribing between the two groups (those favoring and those not favoring generics).

Drug cost emerged as the major reason for prescribing generically, and business philosophy, drug quality, manufacturer reliability, and therapeutic equivalency were reasons cited for not prescribing generically. A majority of the physicians predicted that generic prescribing will continue to increase, but this feeling showed no significant correlation with the number of years which the physician had practiced as measured by the date of his M.D. degree. The physicians who participated in this study indicated that they are involved in the generic prescribing issue with no definite polarization of views observable. If this observation is typical of physicians' opinions and attitudes in general, the practicing pharmacist has a professional responsibility to provide the physician with prescription service

which features reliable medications at reasonable prices.

The pharmacist also has the additional professional responsibility to consult with the physician in the area of generic medications so that quality will not be compromised by price. This calls for a continuing educational effort by the pharmacist, which is in accord with the professional destiny of pharmacy.

Acknowledgements: The authors wish to thank the following individuals for their assistance in developing this study: field research—Jack Mills, James Hines, and Harry O'Cain; typing—Sara McKown and Jeanette Finch.

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*Doctors are always working to preserve our health
and cooks to destroy it, but the latter are the more often
successful.*

—Denis Diderot

EMERGENCY MEDICAL SERVICES

The Medical Association of Georgia Emergency Medical Services Committee, under the direction of Dr. Fleming L. Jolley, Chairman, and in cooperation with the State Health Department, Emergency Medical Services Division, has secured a small packet of emergency medical services material to be delivered to the County Medical Societies. The packet of Emergency Medical Service material will be delivered personally to each county medical society by the MAG field representative, Carl Bailey. If any county medical society is conducting a study related to Emergency Medical Services available and material is needed for this study, arrangements can be made by calling MAG Headquarters for immediate delivery of the Emergency Medical Services material.

Some of the books listed in the Emergency Medical Service kits include: the role of medicine for emergency preparedness, medical requirements for ambulance design and equipment, training of ambulance personnel and others responsible for emergency care of the sick and injured at the scene and during transport, Emergency Resuscitation team manual, a hospital plan, Cardio-Pulmonary Resuscitation, a manual for instructors, the new role of the nurse in Cardiac Arrest, emergency measures in Cardio-Pulmonary Resuscitation, a discussion guide, training of ambulance personnel and Cardio-Pulmonary and Resuscitation, definite therapy in Cardio-Pulmonary Resuscitation, the Dentist's role in Cardio-Pulmonary Resuscitation, the Nurse's role in Cardio-Pulmonary Resuscitation, Physicians Guide for determining driver limitations, proceedings of the American Medical Association Conference on Emergency Medical Services, Conference proceedings on a Community and Emergency Medical Services of the Georgia Department of Public Health Emergency Health Service, Emergency Health Service digest, and Emergency Department.

Many county medical societies have sent in the name of the Chairman of the local Emergency Medical Services Committee; however, if your county medical society has not forwarded this information to MAG Headquarters, please do so as soon as possible. This information will be helpful to Dr. Jolley in distributing further information and setting up plans related to Emergency Medical Services throughout the state.



Carl Bailey, MAG field representative (right) is shown delivering a packet of material on Emergency Medical Services to Dr. F. G. Osborne, Secretary of the Thomas-Brooks-Grady County Medical Society.

The Value of Bronchial Washing Cytology in the Diagnosis of Bronchogenic Cancer

RONALD F. GALLOWAY, M.D., *Augusta*

OVER THE YEARS, various articles and personal conversations with thoracic surgeons have pointed to a diversification of opinion regarding value of bronchial washing cytology as an aid in the diagnosis of bronchogenic cancer. The purpose of this paper is to review our own experience with bronchial washing cytology in an effort to determine its usefulness.

METHOD: Charts on all patients at the University Hospital in Augusta who underwent bronchoscopy with study of bronchial washings for tumor cells were reviewed from January 1, 1964 through December 31, 1969, from the standpoint of whether or not bronchial biopsy was done, whether or not bronchogenic carcinoma was subsequently proven, and as to bronchial washing cytology.

RESULTS: 275 bronchoscopies were done in which bronchial washing cytology was done. One hundred and ninety-six were private patients and 79 were on the staff service. Of all bronchoscopy specimens, 98 cytology examinations were either positive or suspicious for cancer (74 positive, 24 suspicious). A total of 60 biopsies were done, 37 of which were reported as positive and 23 negative. Of all patients included, 135 were proven to have bronchogenic cancer and 137 did not. Three had metastatic cancer to the lung but no primary bronchogenic cancer.

Thirty patients with bronchogenic cancer had positive bronchial biopsy and positive washings (22 per cent). Three patients had a positive biopsy and suspicious washings (2 per cent). Four patients had a positive biopsy and negative washings (3 per cent). A positive biopsy, then, was obtained in 27 per cent of the bronchogenic cancer patients bronchoscoped. Of the patients with bronchogenic cancer but with negative biopsy, eight had positive washings (6 per cent), two had suspicious washings (1 per cent), and seven had negative washings (5 per cent). Twelve per cent of the patients biopsied, therefore, had negative biopsies.

Of the patients in which no biopsy was taken, 32 had positive bronchial washings (24 per cent); 11 had suspicious washings (8 per cent); and 38 had negative washings (28 per cent). Therefore, of all patients with bronchogenic cancer in which the biopsy was negative or in which no biopsy was taken, the washings were positive in 30 per cent and suspicious in 10 per cent, giving a total yield of 40 per cent. Of the 137 patients without cancer, six had "false" suspicious reports (4 per cent) and three had "false" positive reports (2 per cent). Of the three patients with metastatic cancer to the lung, one had positive washings and two had suspicious washings.

SUMMARY: Bronchial washing cytology was reviewed from January 1, 1964 through December 31, 1969. Bronchial cytology was reported as either suspicious or positive in 86 of the 135 patients with bronchogenic cancer (63 per cent). This includes patients in whom the bronchial biopsy was also positive. In patients in whom bronchial washing cytology was relied upon as the sole source of histologic confirmation, there was a yield of 40 per cent (either positive or suspicious).

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There are many gaps in our knowledge, not only in the mechanism of action, but also in the side effects of these agents.

Non-Contraceptive Use of Progestins

PAUL G. McDONOUGH, M.D., F.A.C.O.G., *Augusta, and*
DAVID CARDOSA, M.D., F.A.C.O.G., *Milledgeville*

NEWER PROGESTOGENS are being produced in alarming numbers and it is difficult to assess their respective merits and it is also difficult to know when they are really indicated. Unfortunately, in many instances, the choice of a contraceptive depends only upon the samples available in the physician's office. It is not within the scope of this paper to cover all aspects of gonadal steroids but we would like to discuss the primary difference in progestins, and their therapeutic utility apart from contraception.

The oral contraceptives contain, of course, estrogen and a progestogen which is given in a combined or sequential fashion. It is simpler to think of the sequential preparations as so-called *estrogen dominant* contraceptives since they consist of a rather long course of estrogen followed by a short course of a progestin. The combination pills are perhaps best thought of as *progestin-dominant* preparations since each and every pill contains both estrogen and progesterone.

First of all let us consider the estrogenic component of the pill. The principal estrogen in the body is estradiol. Estradiol given orally has little or no biological activity because it is rapidly degraded, conjugated and excreted by the liver. In order to prevent deactivation of estradiol by the body and prolong its metabolic fate pharmaceutical companies have added an ethinyl grouping in the 17 position. This compound is then known as ethinyl estradiol and is the estrogenic component of Provest, Norlestrin, and Oracon.

Enhanced Potency

You will find as we proceed that the potency of any given estrogen or progestin can be enhanced by two basic types of chemical engineering. The first of these is esterification, and the second type

of chemical manipulation is one in which the number of double bonds in the chemical formula of the compound in question is increased. These chemical alterations render these compounds effective by mouth largely through protection from inactivation by the liver. Along these lines an attempt was made to further enhance the potency of ethinyl estradiol by adding an ether linkage in the three position. This compound was called mestranol or ethinyl estradiol 3 methyl ether (Figure 1). It is the estrogenic component of all the remaining oral contraceptives. However, since the A-phenolic hydroxyl ring is already difficult to break, the addition of the 3 methyl ether linkage did little to enhance the potency of this compound compared to ethinyl estradiol. The practical significance of this in clinical parlance is that the estrogenic component of any oral contraceptive whether it be ethinyl estradiol as in Oracon or mestranol as is present in C-Quens is equal in potency microgram for microgram, that is 100 micrograms of ethinyl estradiol is equal to 100 micrograms of mestranol. It is very important to take notice of the amount of estrogen in a given

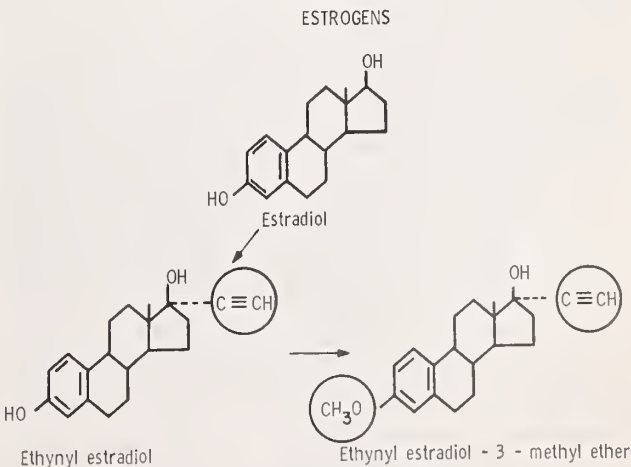


FIGURE 1

Chemical modifications of estradiol in order to produce the two estrogens present in oral contraceptives.

From the Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta, Georgia and Gynecologic Unit, Milledgeville State Hospital, Milledgeville, Georgia.

preparation especially when it is relied upon alone for ovulation inhibition as is true in the sequential or estrogen dominant preparations. In such instances a dose of 100 micrograms affords a higher index of contraceptive safety than does 50 or 80 micrograms of estrogen. For example all the sequential preparations except Oracon contain only 80 micrograms of estrogen. With 80 micrograms of estrogen there is a smaller margin of contraceptive safety should one neglect to take the pill every 24 hours. Such attempts to reduce the amount of estrogen have been made in order to avoid the troublesome side effect of nausea. Nausea in the first few cycles of pill therapy is directly related to the estrogenic potency of the preparation in question. A low incidence of nausea generally implies low estrogenic potency. The lower dose of estrogen present in some sequential preparations reduces troublesome side effects but it does carry with it a higher incidence of breakthrough or surreptitious ovulation.

Another critical time to scrutinize the estrogen concentration is when one is switching a patient from one sequential preparation to another. To simply reach for the next most readily available sample packet can lead to breakthrough ovulation in the succeeding cycle. A patient taking a sequential preparation such as Oracon has been receiving 100 micrograms of estrogen daily for a period of 16 days. All other commercially available sequential preparations contain only 80 micrograms of estrogen. An abrupt switch to another sequential preparation would reduce the patient's daily estrogen intake by 20 micrograms. During this early transitional period breakthrough ovulation may occur. Obviously a patient already on a sequential preparation containing 80 micrograms of estrogen can be switched with safety to a preparation with a higher dose of estrogen.

Estrogen Content

Observation of the estrogen content of certain combined or progestin dominant contraceptives is also important. Since these combined preparations do not effect contraception by ovulation inhibition alone the estrogen content in this regard is not such a critical factor. However, in anticipating the side effects of a given combined preparation the amount of estrogen present, and its biologic interplay with the progestin in the pill, is very important. This is perhaps best illustrated by some examples. Provest, a combined preparation, contains 10 milligrams of Provera and only 50 micrograms of estrogen. Provera, in spite of the fact that it is a pure progestin,

possesses a rather marked amount of anti-estrogenic activity. This anti-estrogenic activity of the Provera infringes on the already small amount of estrogen present and further reduces the total biologically active estrogen present in this preparation. As a result the biologically active estrogen present is less than 50 micrograms and breakthrough bleeding with Provest may become a troublesome problem. This breakthrough bleeding will occur during the early cycles of therapy until sufficient regression of the endometrium has occurred to lessen the incidence of this problem. In spite of the low estrogen content present in Provest it is still highly effective as an antifertility agent because of the combined action of both the estrogen and progestin in inhibiting ovulation, altering cervical mucus, and causing endometrial involution. Enovid is a fine example of an oral contraceptive where the progestin, because of its own intrinsic estrogenic activity, actually enhances the biological activity of the estrogen already present in the preparation. In Enovid-E for example, there are 2.5 milligrams of norethynodrel and 100 micrograms of estrogen in the form of mestranol. However, norethynodrel has of itself some estrogenic activity and as a result the patient exposure in terms of total estrogenic activity is well over 100 micrograms. Signs of estrogen excess such as nausea, and breast tenderness are sometimes seen with Enovid-E and especially with the 10 milligram Enovid tablet. Many of the early reports of alterations in glucose tolerance occurring in patients on oral contraceptives have used the 10 milligram Enovid tablet as the provoking agent. One wonders in these instances whether the glucose intolerance may be more a reflection of the large amount of biologically active estrogen to which the patient is exposed when taking the 10 milligram Enovid tablet which of itself already contains 150 micrograms of estrogen.

Borderline Amounts

The so-called mini-pills with one milligram of a progestin and only 50 micrograms of estrogen are samples of borderline amounts of estrogen. In these mini-pills where the progestin is not capable of significantly augmenting the total estrogenic activity in the pill, breakthrough bleeding is not an uncommon problem. The one milligram pills on the market to date do not contain a progestin with sufficient intrinsic estrogenic activity to prevent a certain percentage, though small it may be, of breakthrough bleeding. An awareness of this problem on the part of some pharmaceutical companies has prompted them to increase the estrogen in these mini-pills from 50 to 80 micrograms. Preliminary experience would seem to indicate that this has been efficacious in

decreasing the percentage of breakthrough bleeding.

In order to understand the non-contraceptive uses of the various progestins it is important to realize that the progestational component of a given pill may be of two essentially different types, one the so-called substituted progestin or C-21 compound and the other the so-called 19 nor-steroid. This distinction is important since there is considerable variation in the biological properties of these two categories of compounds. Substituted progestins resemble pure progesterone in their biologic effects and in their chemical structure. Since they contain 21 carbon atoms they are sometimes referred to as the C-21 progestins. Some examples of such compounds are Delalutin, Provera, and finally Chlormadinone which is the substituted progestin in the sequential preparation known as C-Quens (Figure 2). The more common progestin found in steroid contraceptives is the so-called 19 nor-steroid. These compounds are chemical analogues of testosterone.

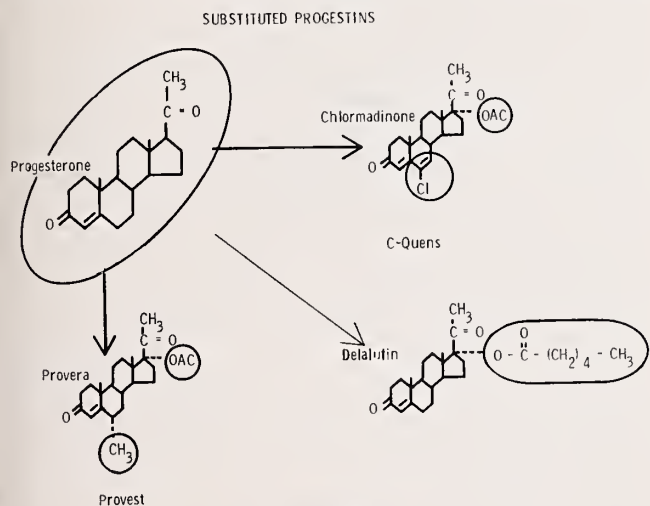


FIGURE 2

Derivation of commercially available pure progestins (C-21) from basic progesterone nucleus.

They closely resemble testosterone in chemical structure except that the methyl group in the 19 position has been removed and thus they are called 19 nor or minus 19 methyl group compounds (Figure 3). Although this group of compounds possess progestational activity it is important to remember that they may possess androgenic activity and in some instances both androgenic and estrogenic activity together. All of the combined or *progestin-dominant* steroid contraceptives on the market at the present time in this country possess the 19 nor-steroids as their progestin except for Provest, which is the only combined preparation containing a substituted progestin or so-called C-21 compound.

Preferred Agents

With this background in mind let us look at

DERIVATION OF NORSTEROID STRUCTURE

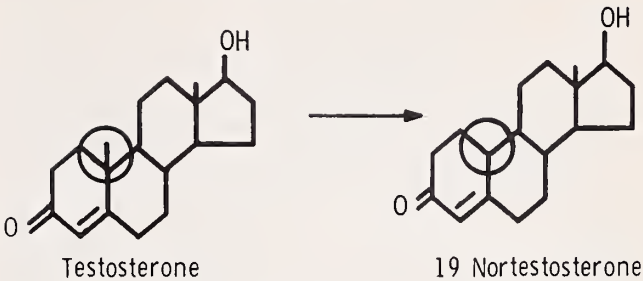


FIGURE 3
Chemical configuration of 19 Nortestosterone.

TABLE I
CONTRACEPTIVE AND NON-CONTRACEPTIVE
USE OF PROGESTINS

- 1. Contraception
- 2. Menstrual Dysfunction
 - a. Dysfunctional Bleeding
 - b. Essential Dysmenorrhea
 - c. Amenorrhea
- 3. Endometriosis
- 4. Hirsute Female
- 5. Acne
- 6. Manipulation of Menses

Table I and select the preferred agent or agents for use in various clinical situations which confront us in day to day practice.

In dysfunctional uterine bleeding with failure of ovulation, bleeding is best controlled by using a combination pill containing a large amount of a 19 nor-steroid and a relatively small amount of estrogen. Clinical experience indicates that progesterone is more effective in the management of atypical bleeding when combined with small amounts of estrogen and/or androgen. The 10 milligram Orthonovum pill is quite efficacious in this regard since it contains 10 milligrams of a 19 nor-steroid and only 60 micrograms of estrogen. To arrest bleeding during the acute stages it is sometimes necessary to give 30 milligrams of this agent during the first 24 to 48 hours of therapy. After arrest of the acute bleeding a maintenance dose of 10 to 20 milligrams can be continued for 30 or more days depending upon the degree of blood loss and pretherapy hemoglobin level. A schematic scheme illustrating this plan of therapy is seen in Figure 4. It is wise to step the dosage down gradually after the first withdrawal period and allow for the re-establishment of a normal pituitary ovarian equilibrium. The small amount of estrogen present in this compound permits the physician to give large amounts of this agent to effect the control of bleeding.⁴

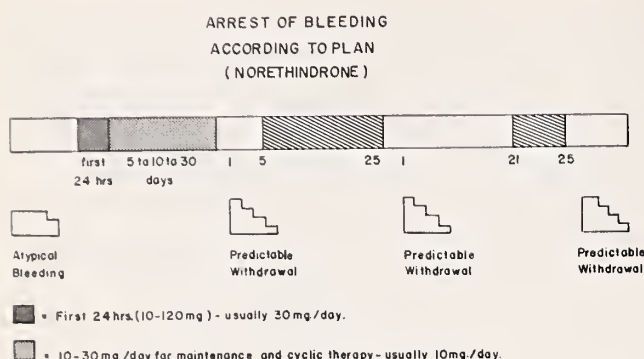


FIGURE 4

Schematic representation of the use of 10 mg. Ortho-Novum to control severe dysfunctional bleeding.

In essential dysmenorrhea the clear cut superiority of one gonadal steroid over another has not yet been established. In instances of essential dysmenorrhea where the patient has a heavy menstrual flow with clots it does seem that the combined preparations are more efficacious. However, those patients who seem to manifest a sensitivity to progesterone respond much better to a sequential regime. If both of these fail then the patient is best treated with 50 micrograms of ethinyl estradiol given from day five to 25 of each cycle.¹

Amenorrhea

In instances of amenorrhea due to a deficit or absence of gonadal steroids such as in the patient with gonadal dysgenesis sequential preparations with rather long courses of estrogen followed by progesterone are most effective in providing for development of secondary sex characteristics and adequate menstrual flow. Oracon containing 100 micrograms of ethinyl estradiol given over a 16-day period followed by five days of a progestin is probably the best choice, unless nausea becomes a problem, then one may switch to any of the other sequential preparations containing less estrogen.³

In the creation of pseudo pregnancy for the management of pelvic pain in endometriosis any combination or *progestin-dominant* pill is adequate, however the 2.5 milligram Norlestrin has been most effective in our hands. The relatively small estrogen content, namely 50 micrograms of ethinyl estradiol, permits one to augment the dose of Norlestrin stepwise without any side effects of estrogen excess. The patient is usually started on a 2.5 milligram tablet until she experiences breakthrough bleeding and then the dosage is doubled, until finally a maintenance dose of approximately 20 milligrams is achieved. This will maintain a decidual-like endometrium for an indefinite period of time. All the

other combined preparations suitable for pseudo-pregnancy contain 100 micrograms of estrogens except for Provest. The larger amount of estrogen in these other preparations may cause nausea in some patients when one attempts to bring the patient to a maintenance level. Provest, although its estrogen content is low, is not suitable for pseudo-pregnancy because of its lack of androgenic properties, and also because of the high incidence of breakthrough bleeding.

Hirsute Females

When one is dealing with the hirsute female who has excessive hair growth on a genetic basis one must carefully select her oral contraceptive. In this type of patient one must avoid all of the 19 nor-steroids because of their androgenic properties. In these patients one should select some combined or sequential preparation which contains a pure progestin or C-21 compound. The ideal combination pill for the hirsute female would therefore be Provest, and the ideal sequential pill would be C-Quens. All the other sequential preparations except for C-Quens contain a progestin with some androgenic properties. It is conceivable that some of the other sequential preparations could be used in the hirsute female in spite of the androgenic nor-steroid since this compound is given in these regimens for no longer than five or six days. There have been some claims that certain oral contraceptives are effective in the treatment of acne by suppressing excessive ovarian androgens. The value of any gonadal steroid in this situation is quite controversial, however, facial tone does seem to improve in some young people when they are given relatively long courses of estrogen. Dermatologists have found Oracon with its large amount and long duration of estrogen therapy as the best agent for management of mild acne. However, it is important to bear in mind that the Dimethisterone which is given over the last five days of this sequential preparation (Oracon) does have mild androgenic properties.

In office practice one is quite commonly confronted by the patient who wishes a delay in the onset of menses for certain practical or social reasons. In this situation, even if the patient is on a sequential regime, if one is to insure a delay in menses one should immediately institute therapy with a combined preparation such as the 2 milligram Ortho-Novum or Norinyl. In general one can delay menses up to 45 days with this type of regime before breakthrough bleeding occurs.

There are of course multiple other clinical situations where gonadal steroids may be used in diagnostic and therapeutic situations. In Table II are listed some situations where a steroid challenge is

TABLE II
NON-CONTRACEPTIVE USE OF PROGESTINS

1. Test of Pregnancy
2. Test of Endogenous Estrogen
3. Abortion Due to Endocrine Cause
4. Patients on Anticoagulant Therapy
5. Inhibition of Growth at Adolescence

helpful in diagnosis, and other clinical situations where endocrine supplementation may or may not be necessary. In delicate social situations where one may elect to use a steroid challenge as a test of pregnancy rather than a pregnancy test certain cautions must be borne in mind. The single girl many times is reluctant to present a urine specimen to the laboratory for a pregnancy test for many good and obvious reasons. In such a situation one can give the patient 20 milligrams of Provera a day for five consecutive days. If the patient has a good adequate withdrawal period then one can be reasonably sure that she is not pregnant. However, if withdrawal bleeding fails to occur after the administration of the oral progestin, it does not necessarily mean that the patient is pregnant. In this regard one must be very careful in interpreting the failure of withdrawal bleeding after a steroid challenge as a positive pregnancy test. The patient may have just ovulated one or two days prior to the initiation of your steroid challenge and as a result her corpus luteum must live out its life span of 14 days before withdrawal bleeding occurs. Secondly the patient may have a prolonged corpus luteum syndrome which is maintaining her endometrium and preventing a withdrawal menstrual period. Prior knowledge of the scope and limitations of a steroid challenge as a pregnancy test perhaps would make a clandestine pregnancy test a better choice in this clinical situation.

Estrogen Testing

In testing for the amount of endogenous estrogen in a patient who perhaps has amenorrhea, one should always use a substituted progestin or C-21 compound as the challenging agent. One may give five days of Provera or Duphaston in this clinical situation. Other agents which are 19 nor-steroids such as Norlutin or Norlutate should not be used since they of themselves possess some intrinsic estrogenic activity and may very well bring about a withdrawal period in the absence of adequate endogenous estrogen.

Recent advances in cytogenetics seem to indicate that a basic endocrine deficit is a rare cause of abortion. However, in those patients where a corpus luteum deficiency may be present and who become pregnant, the best endocrine support is achieved by

the use of Deluteval or Duphaston. Here again it is important to use substituted progestins or C-21 compounds since all of the 19 nor-steroids are capable of masculinizing a female fetus. We have discontinued the use of Provera for endocrine support during pregnancy because of the high incidence of subsequent postpartum menstrual disorders.

A rather select group of patients, but a group which we are seeing more frequently each day, are those patients who have had prosthetic mitral or aortic valve replacements. These patients are on anticoagulant therapy usually with Dicumarol or Coumadin and as a result hypermenorrhea is not an uncommon problem among them. Some of them are not suitable candidates for hysterectomy and we must resort to other methods to manage their bleeding problems. The use of endocrine therapy is naturally a double-edged sword since these patients are prone to embolize from the prosthetic valve itself. In using gonadal steroids to bring about amenorrhea we are using a drug which may be a possible causative or conditioning factor itself in deep vein thrombosis and subsequent embolization. In such patients where future reproduction is not of any concern and who are not operable because of medical reasons we use bimonthly injections of Depo-Provera in 200 milligram dosages. We hope with this form of therapy to bring about complete iatrogenic ablation of menses. In many instances after six or eight months of such therapy the Depo-Provera can be discontinued and the patient may remain amenorrheic. Most of the data of the Medical Research Council of Great Britain seems to link mestranol, ethinyl estradiol, and the 19 nor-steroids as the most likely components of oral contraceptives which predispose to embolic disease. As a result we are resorting to the substituted progestins or C-21 compounds in these patients who have a high propensity for such embolic phenomenon. We feel, however, that hysterectomy is the best form of management for their intractable menorrhagia if it is at all medically feasible. Depo-Provera should never be used in any patient who may be a future candidate for reproduction and subsequent pregnancy.

Growth Inhibition

Large dosages of estrogens have been used in the inhibition of linear growth at adolescence. However, the amount of estrogen which is present in the ordinary contraceptive does not in any way approximate the large dosages that have been used by various investigators to inhibit linear growth in the adolescent girl.² Attempts to inhibit growth even with such massive dosages of estrogens are quite equivocal in their results. Therefore we do not be-

lieve that one need be concerned about administering oral contraceptives in their usual dosage when necessary to an adolescent girl prior to epiphyseal closure.

There are a few other clinical situations where the use of gonadal steroids are controversial (Table III).

TABLE III	
NON-CONTRACEPTIVE USE OF PROGESTINS	
1. Rape	
2. Post-partum Contraception	
3. Children—Accidental Ingestion	
4. Improve Cervical Mucus	
5. Inoperable Fibroids	

One is often confronted with the patient who has been recently raped especially at or just following ovulation. There have been some reports of the use of massive dosages of stilbestrol, usually 50-100 milligrams per day following such exposure, as a pregnancy preventive measure. Whether these drugs may produce an antizygotic or anti-implantation effect due to a toxic effect on the blastocyst, or whether they function by producing alterations in the tubal transport mechanism, is a disputable point. Nausea and vomiting are the most frequently encountered side effects of this therapy. The effectiveness and usefulness of this post-coital type of contraception has not been adequately assessed as yet. More extensive evaluation is necessary. In general when the corpus luteum is well established it is doubtful that any form of gonadal steroid will prevent conception, unless the agent itself has a luteolytic effect on the corpus luteum. As a result in the rape situation we believe that the intrauterine device affords the best protection against a possible unwanted pregnancy.

Postpartum Contraception

There is some controversy as to the timing of the initiation of oral contraception in the postpartum patient. Actually postpartum oral contraception may be started as early as the second or fifth day following delivery. This is assuming that the mother is not breast feeding, since we have very little data as to how much and in what form these agents are excreted in breast milk. When oral contraception is started this early postpartum there are about 6 per cent of patients who will not experience a withdrawal period following this first cycle of therapy. If postpartum contraception is initiated on day 15 postpartum, then the incidence of silent menses de-

creases to 1 per cent or less. The danger of waiting later, of course, carries the risk of a possible ovulation and pregnancy prior to the initiation of contraceptive therapy. Since 50 per cent of patients may initiate ovulation prior to the six week postpartum visit, it would seem most reasonable to start therapy with oral contraceptives on approximately day 15 to 21 postpartum. As regards early initiation of postpartum contraception one must bear in mind that in the first five to seven days postpartum there is a relatively high incidence of deep vein thrombosis and pulmonary embolization. To superimpose upon this normal risk of embolization the possible augmented risk incurred by the use of gonadal steroids would seem to me to be an unwarranted hazard. As a result I believe that it is wiser to wait until postpartum day 15-21 in order to initiate oral contraception. One must also exercise care in the early initiation of postpartum contraception in any patient who has had a severe obstetrical hemorrhage, and may possibly be a potential Sheehan's syndrome. The early postpartum administration of estrogen and progesterone in these patients would of course mask some of the symptoms of pituitary ablation.

One might think that the accidental ingestion of oral contraceptives by children would be a more common occurrence than has been reported in the literature. Fortunately, because of the packaging of the pills, it is rare that a child has the opportunity to ingest more than 20 tablets. Children have been known to swallow as many as 30 tablets of the 2 mg. Ortho-Novum compound with no side effects. Fortunately the estrogen content of most oral contraceptives brings about a sufficient amount of nausea to induce vomiting when they are accidentally ingested by children.

Sometimes during an infertility work-up there is a need to improve cervical mucus in order to facilitate sperm migration. In this situation small doses of ethinyl estradiol usually 20 micrograms given from day 5 to 15 greatly improves cervical mucus and is not sufficient estrogen to inhibit ovulation.

Control Bleeding

We have encountered a few patients with bleeding from uterine fibroids who have medical problems or severe obesity which preclude surgery. In these patients we have used Depro-Provera 200 to 400 milligrams per month in order to control the bleeding. About 15 per cent of these patients do experience some breakthrough bleeding on Depro-Provera alone, however we are willing to except this side effect rather than add supplemental estrogens which could control the breakthrough bleeding.

but would hazard the risk of augmenting the size of the fibroids.

Gonadal steroids, though originally designed primarily for contraceptive purposes, do have many other clinical uses. Future investigation in the use of oral and injectable gonadal steroids for contraception should also provide us with a wider sphere of clinical utility for these compounds. We have touched here upon some of the aspects of our experience with these agents in non-contraceptive situations. There are many and sometimes frightening gaps in our knowledge not only in the mechanism of action, but also in the side effects of these agents. For all the clinical situations which we have discussed each physician must evaluate these risks with a clear appreciation of the many undetermined factors which are involved in the use of these drugs.

In a future paper we hope to cover those clinical

situations where gonadal steroids are contraindicated, or where they should be used with a great deal of caution. We can only appreciate the potential long term effects of estrogen and progestin combinations by further clinical experience gained through properly controlled conditions of observations and careful follow-up.

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CALENDAR OF MEETINGS

In Georgia

Aug. 2-6—National Medical Association, Regency Hyatt House, Atlanta.

Aug. 15-16—Third Annual MAG Committee Conclave, Marriott Motor Hotel, Atlanta.

In the Nation

June 8-10—Association for Gnotobiotics, University of Notre Dame, Notre Dame, Ind.

June 8-12—Internal Medicine 1970: Old Principles—New Practices, University of Iowa, Iowa City.

June 8-12—Psychiatry for the Internist, Psychiatric Institute of the University of Maryland School of Medicine, Baltimore.

June 11-13—California Society of Anesthesiologists, Sahara Tahoe Hotel, Stateline, Nev.

June 13-14—American Diabetes Association, Stouffer's Riverfront Inn, St. Louis, Mo.

June 15-17—American Neurological Association, Sheraton-Deauville Hotel, Atlantic City, N. J.

June 15-17—Cardiac Auscultation, New York University School of Medicine, New York, N. Y.

June 15-17—Blood Transfusion Therapy and Related Immunology, Michigan State University, Dept. of Medicine, East Lansing, Mich.

June 17-21—American Therapeutic Society, Continental Plaza, Chicago, Ill.

June 17-19—Cryogenic Technology Engineering Conference, University of Colorado, Boulder.

June 18-19—American Rheumatism Association, Statler-Hilton, Detroit, Mich.

June 19-21—American Medical Women's Association, Knickerbocker Hotel, Chicago, Ill.

June 20—American Association for the Study of Headache, Continental Plaza Hotel, Chicago, Ill.

June 20-21—American College of Legal Medicine, Chicago, Ill.

June 20-21—Society for Investigative Dermatology, Chicago, Ill.

June 20-21—Society for Surgery of the Alimentary Tract, Conrad-Hilton Hotel, Chicago, Ill.

June 20-21—Society for Vascular Surgery, Conrad-Hilton Hotel, Chicago, Ill.

June 21-25—American Medical Association, Chicago, Ill.

June 21-25—American Physicians Art Association, Chicago, Ill.

June 21-25—Woman's Auxiliary to the American Medical Association, Drake Hotel, Chicago, Ill.

June 22-24—American College of Preventive Medicine, Chicago, Ill.

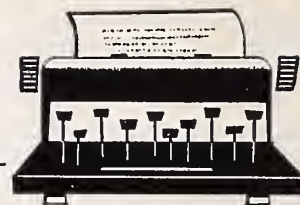
June 22-26—American Veterinary Medical Association, International Hotel, Las Vegas, Nev.

June 23-24—American Medical Society on Alcoholism, Chicago, Ill.

June 24-28—American College of Angiology, Waldorf Astoria Hotel, New York, N. Y.

June 25—Medical Amateur Radio Council, Sheraton-Blackstone Hotel, Chicago, Ill.

June 29-July 1—Conference on Drug Metabolism in Man, Barbizon-Plaza Hotel, New York, N. Y.



1970-AMA Annual Convention

APPROXIMATELY 30,000 physicians, medical students, exhibitors and others are set to descend on Chicago for the 119th Annual Convention of the American Medical Association scheduled for June 21-25.

The world's largest medical convention will highlight a full scientific program for each of the 23 scientific sections in addition to numerous general meetings that cut across speciality lines. Included among the meetings of general interest will be presentations on conception control and abortion; the role of allied health personnel; and the physician's role in sex education.

More than 3,000 industrial exhibits will pack the Chicago Ampitheater as drug houses, equipment manufacturers, book publishers and a host of allied commercial and non-commercial concerns show new and innovative products and ideas. In addition, more than 250 scientific exhibits will be on display.

Extensive use of closed circuit television is planned including a hotel network that will permit viewing of scientific lectures and special programs on hotel room TV sets.

The center of activity of the Annual Convention will be in the House of Delegates, the chief policy-making body of the AMA. The House and its appointed Reference Committees will meet each day of the Convention to ponder and seek solutions to the myriad problems confronting the profession.

Among the items drawing early attention is the so-called "Himler Report," an Ad Hoc Committee study that addresses itself to the total environment of medical practice. The "Himler Report" makes extensive recommendations on virtually every aspect of the profession from basic goals to overriding philosophy; from structural changes to changes in attitude. It is anticipated that this controversial report will receive thorough scrutiny and extensive overhauling by The House of Delegates.

The AMA Convention is naturally not the only thing going on in Chicago. There is another side of that "toddling town" that has a lure equally as strong as the convention itself. Storied and exciting, America's second city, as it likes to call itself, is a tourist mecca with a compelling vitality that is uniquely Chicago. The charm of "Old Town," the Lake Front properties, its famous restaurants, ever-expanding skyline, night life, shopping and all the rest make Chicago the late June place to be.

For a complete rundown on the whole meeting and much that Chicago has to offer, look for the Program Issue soon to be printed in the *Journal of the American Medical Association*.

Why a Woman's Auxiliary?

DEAR DOCTOR,

Do you ever wonder why there **is** a woman's auxiliary to medical societies? What do these women **do**? Back in 1926 it was decided that an *organized group* of doctors' wives could be of help . . . and in several ways.

First, a warmth of fellowship and friendship apparently is helpful in the medical community, and the wives encourage this by meeting occasionally either by themselves or with their husbands.

Second, they may help with entertaining such as district meetings and with special projects.

Third, they work with health-related service projects in the community in order to help show the doctor's concern for the general health. Many of you are too busy or unwilling to give time for this outside of your exhaustive office schedule, but if the public sees your wives doing this, they feel there is a concern other than for the fees to be collected.

Public relations experts say there is a growing resentment against the medical profession in general and that doctors' wives, working as an organized group, can be of tremendous help in overcoming this.

Georgia has 67 medical societies, but only 37 auxiliaries. There are 3,625 members of the MAG, but only 1,880 who are members of the auxiliary. Three hundred ninety-one wives could be members-at-large, where there is no organized auxiliary, but only 99 participate.

There are many ways even one doctor's wife can help improve the image of medicine. She can provide a program for a PTA or youth group by ordering a film from AMA or MAG (your state auxiliary has just purchased an excellent film strip series on Health Careers). She can learn of these through auxiliary meetings, and by reading our state and national bulletins, *The Pulse Line* and *MD's Wife*. They offer many challenging ideas for community service and for providing scholarships for nurses and doctors.

Recently we've been asked to help compile the "History of Medicine in Georgia." We would like to cooperate, but what will we do about the 30 counties where there are no auxiliary members to work on this?

We want to help you, but we need some help from you to do so. We would like you to *want* your wife to be an auxiliary member . . . a dues-paying one even if she is not willing to be active. Her dues and the knowledge she is interested enough to be a member encourage us who are willing to work. You could send a check which is deductible if paid through your office:

a) For members-at-large where there is no auxiliary send \$6.00 (less than the cost of one good steak dinner) to our state treasurer, Mrs. Harry B. O'Rear, 3069 Hillsdale Drive, Augusta, Georgia 30904.

b) Where an auxiliary exists, contact the local treasurer for the exact amount of the dues, as many collect additional money for local projects.

Doctors' wives are intelligent, well-educated, often gifted women. Surely they can help the medical profession show its concern for public health.

The auxiliary's purpose is to help you. Is your wife a member?

*Mrs. S. William Clark, Jr.
Immediate Past President, Woman's Auxiliary
Medical Association of Georgia*

Civilization stands in real danger of overproduction of "undermen."

—J.B.S. Haldane (1892-1964)



WE MUST BE ABOVE REPROACH

EACH YEAR a custom is repeated—a bound volume of the *Journal of the Medical Association of Georgia* is presented to the retiring President as a memento of his year of service to the organization. A part of this volume is the 12 letters from the President to the Medical Association of Georgia membership. Because this tome becomes a part of the family history, it behooves the editor of the President's letter to write items which will bear the test of time.

I am honored, privileged, and flattered to have been chosen by my peers to serve as titular head of the Medical Association of Georgia for the year 1970-1971. Having served on the body politic of the Medical Association of Georgia some 14 years as Councilor from the Eighth District; and, having had the privilege of being on several committees, including that of Finance and Building, and the two most pleasant years as Chairman of Council, I can state without equivocation that the membership of the component societies has chosen some of the finest members of its societies to serve and represent them on Council.

The Medical Association of Georgia is a virile organization and merits the support of each and every physician in the State. Of the approximately 5,000 Doctors of Medicine in Georgia, only some 3,500 are active members of the Medical Association of Georgia. It is true that many are not in active practice and some are in positions in types of practice that do not lend themselves (in the minds of these particular physicians, at least) to desire to be a member of the organization with the rights and privileges to formulate and activate policies of the organization.

A former minister of my Church oft repeated a statement, "If a single preacher is in trouble, then I too am in trouble." The inference is clear and is truly applicable to any profession. We must conduct ourselves as physicians and businessmen such that accusations from various sources are not applicable.

We, as physicians, have been accused, by innuendo, of overcharging the governmental agencies for care and treatment under the Medicare and Medicaid programs. In some small percentage of cases, this has been true. We must police our own ranks to see that just charges are made both ways—a fair charge for services rendered and a fair fee by the paying agency for those services. After all, we pay taxes, too!

By proper peer review and diligent study of utilization procedures, we can maintain our fees for service at a reasonable level.

As a result of our caution that these governmental programs were unrealistically presented at their inception and more recently the accusation of overcharging, we have become the "scapegoats." Incidentally, the derivation of "scapegoat" can be found in the 24th and 25th chapters of Leviticus; a citizen of Old Testament times could heap the results of his sins and misdoings on a goat and banish said goat to the wilderness. This was fine for the sinner, but left a great deal to be desired on the part of the goat.

To those of you who have pursued this letter thus far, please feel free to write and offer suggestions for future communications.

The Council of the Medical Association of Georgia meets quarterly and in various portions of the state, so feel free to visit with Council at any of their meetings, as there are no closed sessions of this body. You are welcome to attend and listen to the business of your association.



F. G. Eldridge, M.D.
President, Medical Association of Georgia

Let each man pass his days in that wherein his skill is greatest.

—Propertius

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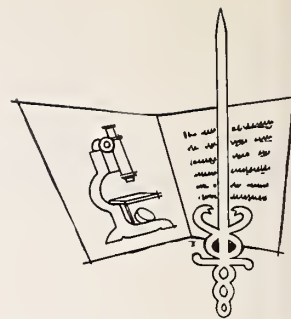
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CANCER CONTROL

HOKE WAMMOCK, M.D., *La Grange*

IT IS ESTIMATED that 13,000 new cancer cases will develop in Georgia for the year 1970. The irony of this is, only one out of three will be cured. If cancer were detected in the early phase and prompt and adequate treatment were applied, we could raise the survival rate to one out of two. Cancer is the second leading cause of death and to help meet this challenge the Medical Association of Georgia has a Committee on Cancer with the duty and responsibility of maintaining and developing a coordinated cancer control program. There are many other agencies and organizations involved in cancer control in Georgia, and a brief historical background seems to be appropriate at this time.

In 1913 the American Cancer Society was organized for the purpose of disseminating information to the public and profession on cancer on a volunteer basis. It was in this year that the first publication appeared in the *Ladies' Home Journal*, entitled, "What Can We Do About Cancer?" by Samuel Hopkins Adams. As the Cancer Society began to grow the Georgia Division was coordinated with the National in 1948 and incorporated in 1949. Thus, the Georgia Division has become a very dominant factor in cancer control in Georgia through its program of education for the laity and the profession, service to cancer patients and funds for research.

Simultaneous with the birth of the American Cancer Society was that of the American College of Surgeons, with the organization of the "Cancer Campaign Committee," the antecedent of the present Committee on Cancer. In 1939 the College of Surgeons began a survey of cancer clinics and today there are over 800 approved cancer clinics throughout the nation. These clinics meet the rules and regulations adopted by the College in 1939, entitled, "Organization of Service for the Diagnosis and Treatment of Cancer, A Minimum Standard."

Regionalization Program

In 1961 the American College of Surgeons developed the Regionalization Program to bring the central office of the College in closer contact with the various cancer clinics throughout the country by dividing the United States and Canada into regions and appointing Liaison Fellows over each region and from the respective College Chapters. In addition to the activities of the College of Surgeons, the College of Physicians, College of Radiologists and College of Pathologists have participated in the Regionalization Program of the College of Surgeons. This has resulted in a homogeneous and vigorous Cancer Control Program in the nation.

One very important function of the College of Surgeons is its role in the development of tumor registries, as this is now of great importance in providing data and information for feedback as to end results and quality control of cancer.

In 1937 the State Legislature of Georgia enacted into law the State Aid Cancer Control Program under the State Public Health Department for the indigent cancer patient, making limited funds available to cancer clinics for the diagnosis and

treatment of cancer. As a result of this, the State Aid Cancer Control Program, there are some 22 cancer clinics in Georgia meeting the minimum requirements of the College of Surgeons. These clinics have provided invaluable service to cancer patients and serve as a focal point for stimulating physicians' interest in the area of cancer.

The Committee on Cancer of the Medical Association of Georgia serves in an advisory capacity to the State Public Health Department, Cancer Control Program.

Regional Medical Programs

In 1965 the Regional Medical Program of Heart, Cancer and Stroke was enacted into Federal law. Shortly thereafter the Medical Association of Georgia began to develop its own Regional Program for Heart, Cancer and Stroke with the Medical Association being designated as a grantee. As for cancer, a task force was appointed which developed a plan for cancer control with the original 22 state aid cancer clinics serving as a springboard and as result of this we have been able to develop a state-wide regional Cancer Control Program. The Regional Medical Program in Georgia is unique in that it is state-wide and there are only three or four other similar programs in the Country. Much progress has been made in the Regional Medical Program for cancer control in Georgia. Twelve cancer clinics have been designated as Area Cancer Facilities. It is planned to designate additional cancer clinics as Area Facilities. The Regional Medical Program in cancer control is engaged in the program of cancer education by providing Seminars on various cancer problems throughout the state. As the tumor registry is a vital part of the cancer clinic, the Regional Medical Program is engaged in updating the tumor registries in the present Area Facility Cancer Clinics. Very soon there will be a print-out of the results of the diagnosis and treatment of various anatomical, histological types of cancer, which will serve as a feedback to the various participating cancer clinics and also provide information for total control of cancer in Georgia.

In 1966 the Medicare Program was enacted into Law and in 1967 was followed by its sister, the Medicaid Program. As a result of this, there has been a reduction in the number of indigent cancer patients being treated in the various cancer clinics and some clinics have closed. It is anticipated that by 1977 the State Aid Cancer Control Program will be phased out and placed under the Medical Assistance Program.

From this brief historical sketch it is obvious that in Georgia we have a very comprehensive cancer control program. The Committee on Cancer is faced with the task of trying to coordinate the various groups engaged in cancer control.

Maintain Progressive Program

What we have is good liaison and rapport with all organizations with one goal in mind and that is to maintain a progressive cancer control program in Georgia, second to none.

During the past summer medical students worked in the various Area Tumor Facilities (cancer clinics), in updating their tumor registries. It became obvious that the students were very hungry for knowledge in the area of cancer and it is hoped that every opportunity will be given them during their medical school career for as much training and learning in the area of cancer as the curriculum will permit. The Committee on Cancer feels very strongly the learning of cancer is from working with patients with cancer.

With the advent of Medicaid and Medicare and the reduction of the indigent case load, the Committee feels that we must strive even harder to coordinate all phases of cancer control in Georgia, developing stronger cancer clinics with adequate facilities for diagnosis and treatment using these clinics as teaching mechanisms for improved quality care in cancer.

West Georgia Cancer Clinic



STRESS AND HEART DISEASE

CURTIS G. HAMES, M.D., *Claxton*

IT HAS BEEN ALMOST TWO CENTURIES since John Hunter made his famous statement that "my life lies in the hands of any scoundrel who chooses to provoke my anger." As recently as the last Georgia Heart Association Meeting, Dr. Oglesbee Paul stated there is no significant evidence of a relationship between stress and heart disease to support it as a major risk factor. Our present state of knowledge lies between these two viewpoints and medical authorities continue to debate the role of stress in the pathogenesis of heart disease. A solution to the problem is urgently needed because of its implied relationship to the tempo of our modern society, and to clarify such phenomena as severe angina and sudden death being precipitated by acute emotional or traumatic events.

For one to gain a proper perspective of the problem, he must first consider the question of semantics. Coronary artery disease represents morphological or structural changes, whereas ischemic heart disease as manifest by angina often represents functional or physiological changes. For example, it is well known that one may have extensive coronary artery disease with no discernible functional impairment or clinical heart disease. Conversely, there may be minimal coronary artery disease yet severe functional impairment or clinical heart disease. The etiological basis for morphological changes in coronary atherosclerotic disease may be entirely different from the etiological factors which precipitate functional or physiological changes.

Ischemic Heart Disease

The type of heart disease so elegantly described by John Hunter is more accurately termed ischemic heart disease and is a physiological or functional failure basically related to oxygen requirements and availability at the cellular level with sequential metabolic and electrical disturbances that may result in ventricular fibrillation or standstill. The catecholamines may be clearly demonstrated as being related to oxygen utilization and have been implicated as one precipitating factor in stress induced sudden death of ischemic heart disease. The factors producing morphological coronary atherosclerotic disease are in general thought to be related to mechanical and metabolic disturbances of the vessel wall, i.e., faulty lipid, carbohydrate or protein metabolism, inflammation, abnormal flow patterns, and thrombus formation, which in our present state of knowledge are considered long-term and not easily related to an acute event as may be measured in minutes. The role of stress in sudden morphological changes, i.e., thrombosis, is less clear. In fact there is good evidence in some cases to demonstrate that thrombosis may occur after infarction.

The current concept of stress is that of a dynamic total organism response of adaptation to our environment. New information on the stress reaction may elucidate the mechanisms for a better understanding of stress and heart disease and can be summarized as follows: (1) a variety of hormones regulate cellular

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

metabolism and respond to "stress"; (2) the autonomic nervous system affects both metabolism and cardiovascular function and is the acute mediator of stress reactions; and (3) there is a prominent cerebral integration of psychic and physiologic stimuli and responses.

In conclusion, the production or propagation of heart disease by stress represents a truly multi-factoral problem. To begin to understand the relationship of stress to heart disease, one must first define the specific type of heart disease, i.e., functional impairment or morphological changes. Second, the nature of a particular individual's psychic and endocrinological responses to a given environmental "stress" situation must be evaluated. It is only by looking at this problem in concise qualitative and quantitative terms that real progress can be made in its understanding.

Claxton, Georgia 30417

SUPPLY HOUSES HELP DOCTOR-OF-THE-DAY

The Doctor-of-the-Day program, a volunteer service project of the MAG Committee on Legislation, through which physicians give a day's service as the doctor on duty during the time of the General Assembly, has completed its second successful year.

The program is acknowledged by most who served during the 1970 session as one of the finest public relations projects the Association has participated in in recent years.

Outfitting the Medical Aid Station is always one of the major considerations which we endeavor each year to provide as a service to the members of the

Legislature. It is in this regard that the Legislative Committee would like to publicly acknowledge a debt of gratitude to the American Surgical Supply and Estes Surgical Supply for their splendid cooperation in the loan of necessary equipment.

Both of these Atlanta-based supply houses deserve a measure of credit for the success of the project. The Doctor-of-the-Day program was helped immeasurably by their generous contribution and, because of their assistance, remains a useful addition to the Capitol scene during the regular sessions of the Georgia General Assembly.

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THE ASSOCIATION



NEW MEMBERS

Bourne, Peter G. Active—Fulton—P	1039 Ridge Ave., S.W. Atlanta, Georgia 30315	Laslie, Michael N. Active—S. W. Ga.—GP	322 S. Main Street Blakely, Georgia 31723
Braganza, T. J. Active—Muscogee—P	2000 16th Ave. Columbus, Georgia 31901	Markle, C. David Active—Cobb—I	2271 Austell Road Austell, Georgia 30001
Caplan, Daniel B. Active—Fulton—Pd	69 Butler Street, S.E. Atlanta, Georgia 30303	Morrison, Charles W. Active—Ga. Medical—Pl	11 Medical Arts Center Savannah, Georgia 31405
Carlton, Frank E. Active—Ga. Medical—U	2515 Habersham Street Savannah, Georgia 31401	Nance, Dana W. Active—Cobb—Su	737 Church Street Marietta, Georgia 30060
Carter, Robert H. Active—Ga. Medical—Su	201 E. Hall Street Savannah, Georgia 31401	Nettles, Joe L. Active—Ga. Medical—Or	8 Medical Arts Center Savannah, Georgia 31405
Clarke, George D. Active—Ga. Medical—Anes	13 Medical Arts Center Savannah, Georgia 31405	O'Brien, Mark S. Active—Fulton—NS	1365 Clifton Road, N.E. Atlanta, Georgia 30322
Cohen, Paul G. DE-2—Fulton—I	69 Butler Street, S.E. Atlanta, Georgia 30303	Oglesby, William H. Active—Tift—GP	4th Street & Central Tifton, Georgia 31794
Costa, Conrado V., Jr. Active—Ga. Medical—GP	601 Abercorn Street Savannah, Georgia 31401	Olson, Clyde L. Active—Ga. Medical—OPH	701 Abercorn Street Savannah, Georgia 31402
Daniell, Duren, Jr. Active—Sumter—GP	Riverside Hospital Montezuma, Georgia 31063	Piatt, Edward D. Active—Ga. Medical—R	9 Medical Arts Center Savannah, Georgia 31405
Dekle, John L., Jr. Active—Ga. Medical—OBG	2512 Habersham Street Savannah, Georgia 31401	Rey, Roberto A. Active—Baldwin—P	Central State Hospital Milledgeville, Georgia 31062
Dent, John M., Jr. Active—Tift—OBG	310 E. 6th Street Tifton, Georgia 31794	Smith, Don T. Active—Tift—GP	736 East 18th Street Tifton, Georgia 31794
Dudley, A. G. DE-4—Sumter—OBG	7520 USAF Hospital 1031 APO New York 09125	Sowell, Raymond H., Jr. Active—Ga. Medical—P	P.O. Box 6688 Savannah, Georgia 31405
Edmondson, Stephen W. Active—Fulton—P	6075 Roswell Rd., N.W. Atlanta, Georgia 30328	Tillinger, Arnold J. Active—Ga. Medical—P	5102 Paulsen Street Savannah, Georgia 31405
Garay, G. V. Active—Ga. Medical—Path	P.O. Box 6688 Savannah, Georgia 31405	Vaughn, John Active—Ga. Medical—Path	601 Abercorn Street Savannah, Georgia 31401
German, Thomas L. Active—Ga. Medical—Or	210 Hall Street East Savannah, Georgia 31401	Wade, John S. Active—Ga. Medical—Su	122 E. Gaston Street Savannah, Georgia 31401
Graham, Cecil C. Active—Ga. Medical—Anes	13 Medical Arts Center Savannah, Georgia 31405	Wallace, Stuart M. Active—Ga. Medical—Path	206 E. 36th Street Savannah, Georgia 31403
Haberman, George G. Active—Ga. Medical—Su	601 Abercorn Street Savannah, Georgia 31401	Wilson, Roy G. Active—Ga. Medical—Pl	5105 Paulsen Street Savannah, Georgia 31405
Hadaway, Phil L. Active—Ga. Medical—GP	819 East 66th Street Savannah, Georgia 31405	Wolfe, William W., Jr. Active—Ga. Medical—P	5102 Paulsen Street Savannah, Georgia 31405
Koen, Leon Active—Baldwin—Su	Central State Hospital Milledgeville, Georgia 31062		
Larose, James H. Active—Fulton—R	475 Woodruff Building Atlanta, Georgia 30322		

SOCIETIES

Members of the Woman's Auxiliary to the **Ogeechee River Medical Society** honored their doctors on "Doctor's Day" in March with a dinner at the Willow Lake Golf and Country Club.

ASSOCIATION / Continued

The **DeKalb Medical Society** had Paul Crane, M.D., missionary to Korea, as guest speaker for their March meeting. Dr. Crane spoke on "Types of Medicine Used in the Orient."

PERSONALS

Second District

Charles B. Gillespie has been certified as a Diplomat of the American Board of Orthopaedic Surgery.

Fourth District

Ernest White Abernathy, Jr., will team with an anesthesiologist to perform surgery one day a week at the Sylvan Grove Hospital in Butts County, giving the hospital its first surgical tandem since its opening.

Fifth District

During the month of March **Bruce Lodge** addressed the Bowman Gray School of Medicine, Winston-Salem, N.C., on "Some Aspects of the Clinical Pharmacology of Cardiovascular Disease"; served on a panel discussion of the American College of Cardiology in New Orleans, La., on "Treatment of Angina Pectoris"; spoke to the International College of Dentists in Atlanta on "Dentists and Coronary Disease," and gave the first annual Elliott Faison Lectureship in Charlotte, N.C., on "Coronary Disease 1970."

William Futch addressed the February meeting of the Rockdale County Jaycees, discussing his search for another physician to serve the Conyers area.

A. S. Haraszti toured Hungary for three weeks in February, visiting Hungarian churches and hospitals.

Simon Krantz received the Fellowship degree of the American College of Radiology at that organization's annual meeting April 3 in Dallas, Tex.

Lea Richmond spoke on sex education at a special program in March sponsored by the Huntley Hills Parent-Teacher Association.

Seventh District

Luther Fortson has been elected vice president in charge of Project Review of the Metropolitan Atlanta Council for Health. He has also been elected president of the Emory University Medical Alumni Association.

John J. Allen has begun practice in the Emergency Department of Hamilton Memorial Hospital.

Dolores Stough has opened offices in Austell for the practice of Internal Medicine.

Ronald Tipton has been elected chairman of the Whitefield County Health Planning Council.

Eighth District

W. O. Inman, Jr., discussed the cellular components of blood at the March meeting of the Glynn Academy Science Club.

Jesse Lyle Parrott has been re-elected to active membership in the American Academy of General Practice.

Tenth District

M. C. Adair has been re-elected to active membership in the American Academy of General Practice.

Ira Goldberg has been elected a director of Augusta's First Federal Savings and Loan Association.

DEATHS

John Harvey Norton, Jr.

John Harvey Norton, Jr., died March 19 in a Rome hospital after an illness of six weeks.

He attended Auburn University, received his pre-medical education at Emory University, and was graduated from the Medical College of Georgia in 1947. He practiced medicine in Cave Springs from then until his death.

Dr. Norton was a member of the First Baptist Church in Cave Springs, the Mackey Lodge of Masons, Yaarab Temple and the Low 12 Club. He was also a member of the Medical Association of Georgia and the Floyd County Medical Society. Dr. Norton served with the Air Force during World War II and the Korean War.

He is survived by his widow, the former Kay Strickland; two sons, John Harvey Norton, III, Cave Springs, and Connell Snead Norton, Rome; one step-son, Charles W. Camp, II, U.S. Air Force, Panama City, Fla.; one daughter, Miss Corinne Sutherlin Norton, Rome; his mother, Mrs. F. W. Shropshire, Rome; one sister, Mrs. Horace Cline, Cave Springs; one niece and one nephew.

C. G. Redmond

C. G. Redmond died at his residence in Savannah March 18 after a long illness. He was 85.

Dr. Redmond was graduated from the Medical College of Georgia in 1907 and did postgraduate study at New York University. He began practice in Savannah in 1912, retiring several years ago after 59 years of practice.

He was a member of the Independent Presbyterian Church, the Masonic Order of Blackshear, and the Scottish Rite. Dr. Redmond had been vice president of the Georgia Medical Society and the Medical Association of Georgia.

He is survived by his son, C. R. A. Redmond, M.D., of Savannah; a sister, Miss Ouida Redmond of Savannah; two granddaughters, Mrs. Bruce Gordon and Mrs. Robert L. Robinson, III, both of Savannah; a grandson, Spec. 4 C. R. A. Redmond, Jr., with the U.S. Army in Korea, and two nieces.

GEORGIA HEART RESEARCH GRANTS

The Georgia Heart Association has announced the allotment of more than a quarter of a million dollars to Heart Research. The grants include \$169,243 for support of twenty-one research studies in Georgia institutions and \$110,191 to the national research program of the American Heart Association.

Dr. Thomas D. Johnson, of Albany, President of the GHA, pointed out that the local Heart Fund awards provide continuing support for a Chair of Heart Research and a Senior Investigatorship at each of the state's two medical schools and one-year grants-in-aid to 17 teams of scientists for research in the cardiovascular field. All grants are for the 12-month period ending June 30, 1970, he said. He noted that these are in addition to awards made by the American Heart Association to Georgia investigators.

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Contents

Official Proceedings, 116th Annual Session of the Medical Association of Georgia, May 7-10, 1970, Jekyll Island, Georgia.

HOUSE OF DELEGATES

First Session	
Friday, May 8, 1970	201
Second Session	
Sunday, May 10, 1970	229

GENERAL BUSINESS SESSIONS

First Session	
Thursday, May 7, 1970	199
Second Session	
Friday, May 8, 1970	200
Third Session	
Sunday, May 10, 1970	227

Editorials

W. C. MITCHELL OF SMYRNA INSTALLED AS PRESIDENT-ELECT	267
PITFALLS IN THE CATHETERIZATION OF THE SNAKE Fleming L. Jolley, M.D.	267
HIGHLIGHTS OF THE 1970 MAG ANNUAL SESSION	268

Features

President's Letter	272
------------------------------	-----

The Association

New Members	274
Societies	274
Personals	274
Deaths	274

Cover

Design by Marie Seaman.

PROCEEDINGS INDEX

MAG GENERAL BUSINESS SESSIONS		General Business Session
(First Session)		First
President-Elect's Address	199	
(Second Session)		Second
Report of Woman's Auxiliary	200	
(Third Session)		Third
MAG Memorial Service	227	
Certificates of Appreciation	227	
Fifty Year Awards	227	
Life Membership Awards	228	
GaMPAC Awards	228	
Distinguished Service Award	228	
Site of Future Annual Sessions	228	
Installation of Officers	266	
MAG HOUSE OF DELEGATES		
(First Session)		House of Delegates
Attendance	201	
Credentials Committee	202	
Tellers Committee	202	
Reference Committees	202	
Approval of 1969 Minutes	202	First Session
Nominations	202	
GP of the Year Award	204	
Referral of Reports		
Officers	204	
Councilors and Vice Councilors	204	
Association Committees	204	
Special Reports	205	
(Second Session)		Second Session
Attendance	229	
Election of Delegates	230	
Report of Reference Committee A	230	
Report of Reference Committee B	234	
Report of Reference Committee C	242	
Report of Reference Committee D	256	
Report of Reference Committee E	260	
Reports Not Referred		
President	205	
President-Elect	205	
Past President	205	
Secretary	206	
Auditor's Statement	207	
First District Councilor	210	
Second District Councilor	210	
Third District Councilor	210	
Sixth District Councilor	211	
Seventh District Councilor	211	
Eighth District Councilor	211	
Ninth District Councilor	212	
Tenth District Councilor	212	
Bibb County Medical Society Councilor	212	
Bibb County Medical Society Vice-Councilor	213	
DeKalb County Medical Society Councilor and Vice-Councilor	213	
Fulton County Medical Society Councilor	213	
Georgia Medical Society Councilor	213	
Muscogee County Medical Society Councilor	213	
Richmond County Medical Society Councilor	214	
Annual Session Committee	214	
Blood Banks Committee	214	
Disaster Medical Care Committee	214	
Finance Committee	215	
Governmental Medical Services Committee	215	
Historical Committee	215	
Medicine and Religion Committee	215	
Mental Health Committee	215	
Professional Conduct and Medical Ethics Committee	216	
Rural Health Committee	216	
Separate Billing Committee	216	
The Journal	217	
Woman's Auxiliary	217	
Georgia Regional Medical Program	218	
Operational Projects of Georgia Regional Medical Program	219	
AMA Delegates	221	

Reports, Reference Committee Recommendations and Delegates' Actions:

Report of Reference Committee A

Speaker, House of Delegates	230
Vice Speaker, House of Delegates	231
Woman's Auxiliary Advisory Committee	231
Maternal and Infant Welfare Committee	231
Nursing Liaison Committee	233
Resolution 70-2 (Election Procedure of the GP of the Year)	233
Resolution 70-4 (Abortion Laws)	234
Resolution 70-16 (Medicaid Payment for Sterilization)	234

Report of Reference Committee B

First Vice-President	234
Chairman of Council	235
Attachment to Chairman of Council 70-1 Rejection of Himler Report	236
Fulton County Medical Society Councilor	239
Allied Health Careers Committee	239
Areawide Health Planning Committee	240
Medical Education Committee	240
Supplemental Report of Council	241
President-Elect's Address	241
Resolution 70-20 (Committee to Study Malpractice Suit Problem)	242

Report of Reference Committee C

Alternate Delegate to AMA	242
Constitution and Bylaws Committee	243
Constitution and Bylaws Committee	
Supplemental Report 70-1	246
Supplemental Report 70-2	246
Legislation Committee (National)	248
Legislation Committee (State)	251
Occupational Health Committee	253
Physician-Lawyer Liaison Committee	254
Resolution 70-5 (Voluntary Proficiency Testing of Physician Office Laboratories)	254
Resolution 70-10 (Repeal of State Laws on Serological Test for Syphilis as a Prerequisite for Marriage Licenses)	254
Resolution 70-13 (Chiropractic)	255
Resolution 70-15 (GaMPAC Commendation)	255

Report of Reference Committee D

Second Vice-President	256
Cancer Committee	256
Insurance and Economics Committee	257
Medical Review and Negotiating Committee	258
Resolution 70-1 (Peer Review)	259
Resolution 70-11 (MAG Establish a Committee on Private Practice)	259
Resolution 70-14 (Let the Bedside Physician Be the Guideline)	259
Resolution 70-17 (Workmen's Compensation)	259
Resolution 70-18 (Fraud Disclaimer on Medicaid Claim Forms)	260
Resolution 70-19 (Support of Hospital Utilization and Review Committees)	260

Report of Reference Committee E

Cobb County Medical Society Councilor	260
Emergency Medical Services Committee	261
Public Service Committee	261
School Child Health Committee	262
Resolution 70-3 (Medical Systems for Mass Casualty Situations)	264
Resolution 70-6 (Availability and Abuse of Amphetamines and Other So-called Appetite Suppressants)	264
Resolution 70-7 (Commendation to Kiwanis Clubs of Georgia for Activities in Drug Abuse)	264
Resolution 70-8 (Commendation to Georgia Junior Chamber of Commerce for Activity in Emergency Medical Services)	265
Resolution 70-9 (Commendation to Lions Clubs of Georgia for Leadership in Foundation for the Blind)	265
Resolution 70-12 (Endorsement of Traffic Safety Legislation)	265

MAG GENERAL ASSEMBLY

A. W. Calhoun Lecture	224
---------------------------------	-----

MAG ANNUAL BANQUET

Certificates of Appreciation	225
Scientific Exhibits Awards	225
Golf Prizes	225
Tennis Prizes	225
Art Exhibit Prizes	226
Medical Mile Award	226
Civic Endeavor Award	226
Hardman Cup Award	226

MAG General Session (First Session)

116th Annual Session of the Medical Association of Georgia

Thursday, May 7, 1970

THE FIRST GENERAL SESSION of the 116th Annual Session of the Medical Association of Georgia was called to order by President John Kirk Train, Jr., Savannah, at 1:30 p.m. in the Rotunda of the Aquarama, Jekyll Island, Georgia, on May 7, 1970.

Dr. Train welcomed those members present and stated that while enjoying the splendid hospitality of Jekyll Island and the Glynn County Medical Society, it was most appropriate to count our blessings and give thanks together. Dr. Train then called on the Reverend Dan Thomas, Jr., Chairman of the Glynn County Ministerial Association, to lead the General Session in the invocation.

Dr. Train then presided as the Color Guard from the Glynco U.S. Naval Air Station presented the colors, and the national anthem was sung by Mrs. George W. Statham of Atlanta, accompanied by the Brunswick High School Band under the baton of director Denzil Sellers.

For the further entertainment of the members, Woman's Auxiliary and guests present, Mr. Sellers and the Brunswick High School Band presented a brief program of music.

President Train then recognized the Past President of the Glynn County Medical Society, Dr. Burt Malone, of Brunswick, who extended words of welcome to the Association from the host society.

President Train then recognized Mr. Frederick Griffith, Assistant Director of the Jekyll Island Authority, who brought greetings to the Association.

President Train then introduced Mr. Lawrence Roush of the National Park Service, Fort Frederica, Georgia, who welcomed the Association and presented the new Park Service film entitled, "This Is Frederica."

President Train then called on President-Elect Franklin Gooding Eldridge, of Valdosta, who pre-

sented his Incoming President's Address to the Association membership on "The Challenge to MAG."

President-Elect's Address

F. G. ELDRIDGE, M.D.

I feel that a high honor has been bestowed upon me and I am deeply appreciative of the fact that I have been chosen as President of the Medical Association of Georgia for the year of 1970-71. Following in the footsteps of John Kirk Train, Charlie Andrews, John Mauldin, Walter Brown, George Alexander, J. G. McDaniel, and many others will require the utmost effort on my part. With your help, the Medical Association of Georgia team effort will continue as it has in the past several years. Many of you have worked tirelessly in an effort to promote the ideals of the Art and Science of Medicine as well as the business of medicine.

Much has been accomplished in the management of the governmental agency programs such as Medicare, Medicaid, and the Regional Medical Programs in the past; however, strong emphasis needs to be placed on cooperation between physicians and the various agency programs so that the patient will not suffer as a result and the economy of health care be destroyed. Several programs are under consideration and the American Medical Association Medi-Credit Program appears to have a great deal of merit.

The average physician in the United States, according to recent studies, spends approximately 60 to 65 hours in the practice of his profession each week, but this dedication of time is not enough to supply all the needs of medical care for all the populace. The supply of physicians is very short and the demand is very strong. All indications point to the fact that this short supply will not increase very rapidly in the near future and certainly not rapidly enough to cope with the population increase; hence, we as physicians should cooperate in every possible way to increase the supply of properly trained physicians.

In the past years, good medical care has been considered as a privilege. However, within the past few years and as time progresses, public opinion has and

will change, and good medical care will become considered a right.

The American Medical Association plans to launch a National Membership Drive in 1970, and we urge each of you to support this drive both at local, state, and national levels.

As the availability of medical care by physicians decreases the medical frauds and quacks will increase to fill the vacuum. This trend should be exposed to the public for just what it is.

On a state level, your Medical Association of Georgia constantly increases in growth, activities, strength, and influence throughout the state. To those of us who have been privileged to serve in this growth, we take great pride.

We have a most efficient staff and very impressive headquarters to house this staff, and to administer the many quality programs that have been originated and maintained. Even though our staff is most efficient, additional members will, of necessity, have to be added to take care of new and additional programs in the future.

I would like to submit recommendations for 1970-71 as follows:

1. The formulation of a strong committee for peer review.
2. The formulation of a strong committee for utilization of all health care facilities that come within the scope of the profession.
3. The formulation of some workable method to present the views and activities of the medical profession to the public, and to the press, to offset adverse publicity that emanates from various sources all too frequently. A Public Relations Council or Committee would be helpful.
4. We must provide strong support of the PAC programs, both GaMPAC and AMPAC. Incidentally, the basic tenet of the PAC program is to aid in the selection and election of individuals to whom we can communicate.

5. We must conduct a study of the dues structure of the Medical Association of Georgia with proper adjustments to be made when feasible and necessary. The average dues of the 50 State Medical Societies is approximately \$92.00 annually, ranging from the low (Georgia) annual dues of \$40.00 to the high, (Alaska) of \$200.00.

6. We must aid in the education, recruitment, and support of all ancillary medical personnel, and para-medical personnel of all types.

7. We need to continue support of the Woman's Auxiliary by every means possible.

8. We must become involved in local problems of education, mental health, aging, environmental conditions, drug abuse, and other situations which will aid in the promotion of good health of the public in general.

It is well known that each of you are busy in your practice and also have outside interests. Many of you will be requested to serve on the various committees and to supply your expertise in the Medical Association of Georgia structure, but it is also well known that busy people are the ones you can depend on and will accomplish the most in fields other than their own when their interest is properly aroused and their enthusiasm procured.

In conclusion let me issue an invitation to each and every member of the Medical Association of Georgia to visit with your Council at one of their quarterly meetings and see what transpires. You will find very, very busy people at work on problems and the solutions of problems that affect you directly, as well as indirectly.

There being no further business, President Train recessed the First General Session of the 116th Annual Session of the Medical Association of Georgia at 3:30 p.m.

MAG General Session (Second Session)

116th Annual Session of the Medical Association of Georgia

Friday, May 8, 1970

THE SECOND GENERAL SESSION of the 116th Annual Session of the Medical Association of Georgia was called to order by President John Kirk Train, Jr., of Savannah, at 9:00 a.m. in the Rotunda, Aquarama, Jekyll Island, on May 8, 1970.

President Train recognized the Reverend Talbert Morgan, Rector of Saint Marks Episcopal Church, Brunswick, who opened the meeting with an invocation.

President Train then called on Dr. W. C. Mitchell, of Smyrna, Chairman of the Advisory Committee to the Woman's Auxiliary, to escort Mrs. Charles R. Smith of Columbus, President-Elect of the Woman's Auxiliary to the Medical Association of Georgia, to the podium, where she delivered the report of the MAG Auxiliary in behalf of Mrs. S. William Clark, Jr., of Waycross, President of the MAG Auxiliary. Mrs. Smith brought the report to the Annual



Mrs. Charles R. Smith,
Columbus, Georgia

Session and then introduced to the audience Mrs. John Chenault of Decatur, Alabama, President of the Woman's Auxiliary to the American Medical Association, who was attending the MAG Annual

Session as a guest and program participant during the Annual Sessions of the Woman's Auxiliary to the Medical Association of Georgia.

President Train then announced that two special guests would be extended the privilege of the floor for brief remarks to the Association. President Train explained that we have recently witnessed a rebirth of activity in the two Student AMA Chapters in Georgia as well as advances in Student Concerns and activity nationally, and that the presidents of the two Student AMA Chapters were providing leadership in Georgia. Dr. Train first introduced John R. Cone, President of the SAMA Chapter at Emory University, who delivered a message to the Association. Dr. Train then recognized Ronald W. Digby, President of the SAMA Chapter at the Medical College of Georgia, who also spoke to the Association.

At this point, President Train announced that the Second MAG General Session would be adjourned and that the meeting would be turned over to Dr. Harrison L. Rogers, Atlanta, Speaker of the MAG House of Delegates, to preside at the First Session of the MAG House of Delegates' meeting.

First Session, House of Delegates

Friday, May 8, 1970

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., Atlanta, at 10:15 a.m. in the Rotunda, Aquarama, Jekyll Island, Georgia, in conjunction with the 116th Annual Session of the Medical Association of Georgia. Speaker Rogers extended a warm welcome to the Delegates in attendance and briefly reviewed the schedule for the transaction of business by the House of Delegates during its two 1970 Sessions, including the Reference Committee system and their schedules for meetings.

Speaker Rogers then called for a report of the Delegates in attendance. Dr. Robert J. Moye, of Swainsboro, Chairman of the House of Delegates' Credentials Committee, reported that there were 163 Delegates present and registered, representing 51 component societies, and that there was a quorum of more than 40 members present and accounted for. A complete report made by the Credentials Committee on the attendance at the First Session at the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 51 county medical societies were presented by their duly elected delegates or alternates. Of a total 163 authorized delegates by their respective medical societies, the official roll showed 137 delegates present at this First Session.

ALTAMAHA: E. J. Virusky; BALDWIN: E. W. Allen, Jr.; BIBB: Charles A. Lanford; Charles G. Burton; A. L. Mayes; Henry H. Tift; Henry C. Drake; Alexander H. S. Weaver; OGEECHEE RIVER: Leon E. Curry; CARROLL-DOUGLAS-HARALSON: J. L. Boss; Phil C. Astin; GEORGIA MEDICAL SOCIETY: F. P. Bousquet; Robert Logan; F. D. Maner; A. F. Williams; J. P. Evans; Edwin C. Shepherd; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: F. A. McElhannon; T. A. Montgomery; Donald Branyon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark; Donald R. Rooney; Stephen C. May; James H. Manning; Noah D. Meadows; Luther G. Fortson; COFFEE: R. L. Benson; COLQUITT: R. M. Joiner; DECATUR-SEMINOLE: Henry Bridges; DEKALB: M. Hobson Rice; Luther

M. Vinton; Ellis B. Keener; John P. Heard; Knox Walker, Jr.; O. W. Stubbs, Jr.; Robert M. Fine; DOUGHERTY: J. D. Bateman; C. D. Hollis; Robert Waller; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: James H. Smith; W. Henry Lucas; Harold G. Robinson; Jack R. Meacham; FULTON: Harrison L. Rogers, Jr.; A. A. Rayle, Jr.; J. Harold Harrison; Spencer S. Brewer; William D. Logan; Charles E. Todd; William L. McDougall, Jr.; F. William Dowda; William W. Moore, Jr.; Thomas J. Anderson, Jr.; J. Rhodes Haverty; Joseph L. Girardeau; Edwin C. Pound; Chenault W. Hailey; William E. Huger, Jr.; J. G. McDaniel; Neil G. Perkinson; Robert E. Wells; Hugh S. Thompson, Jr.; Edwin C. Evans; J. Frank Walker; Joseph S. Wilson; L. Newton Turk, III; Henry M. Finch; John S. Atwater; L. Harvey Hamff; John N. McClure; Byron F. Harper, Jr.; Robert F. Finegan; C. R. Moorhead; Joseph Hertell; J. Watts Lipscomb; John Schellack; James A. Kaufmann; Allan Bleich; Milton B. Satcher; GLYNN: C. A. Wilson; GORDON: Bill Purcell; HABERSHAM: Tom Lumsden; HALL: A. F. Bloodworth; Billy S. Hardman; C. W. Whitworth; PEACH BELT: Virgle W. McEver; H. E. Weems; JACKSON-BANKS: E. W. Holloway; JEFFERSON: C. Roy Williams; LAURENS: W. M. Watkins; McDUFFIE: Thomas E. Averitt; MERIWETHER-HARRIS: J. E. Collins; MUSCOGEE: Luther J. Smith; Henry H. Boyter; T. Jack McGee; Jack Hirsch; NEWTON-ROCKDALE: J. R. Sams; OCONEE VALLEY: C. H. Dickens; OCMULGEE: W. E. Coleman; POLK: Don Schmidt; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Stuart H. Prather, Jr.; Cecil A. White, Jr.; Julius T. Johnson; Ronald F. Galloway; Preston D. Ellington; Clyde A. Burgamy; William A. Fuller; Menard Ihnen; Henry Scoggins; Walter L. Sheppard; J. Kenneth McDonald; SOUTH GEORGIA: H. B. Smith; Joe Stubbs; SPALDING: Alex P. Jones; STEPHENS: Irving Helenga; SUMTER: J. H. Robinson, III; TELFAIR: Frank R. Mann; THOMAS-BROOKS-GRADY: Thomas Lear; Frank Miller; TIFT: Joe Turner; TROUP: Charles T. Cowart; WALKER-CATOOSADADE: Robert T. Jones; F. J. Smiley; UPSON: T. A. Sappington; WARE: Floyd E. Davis; S. W. Clark; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee; J. E. Marlow; WILKES: M. C. Adair; WORTH: H. G. Davis, Jr.

Speaker Rogers then introduced the Vice Speaker of the House, Preston D. Ellington, M.D., of Augusta, and explained fully the methods of consideration of business to be brought before the House of Delegates.

Speaker Rogers then announced the appointment of the House of Delegates' Credentials Committee and the appointment of the House of Delegates' Tellers Committee as follows:

CREDENTIALS COMMITTEE: R. J. Moye, Swainsboro, Chairman; F. M. McElhannon, Athens; and Albert A. Rayle, Atlanta.

TELLERS COMMITTEE: John P. Heard, Decatur, Chairman; Charles A. Hodges, Valdosta, and E. J. Virusky, Baxley.

Speaker Rogers then appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: W. Henry Lucas, Rome, Chairman; Phil C. Astin, Carrollton, Vice Chairman; Henry D. Scoggins, Augusta; C. D. Hollis, Albany; C. H. Harper, Folkston; William D. Logan, Atlanta.

REFERENCE COMMITTEE B: John G. Bates, Cuthbert, Chairman; Noah D. Meadows, Marietta, Vice Chairman; William L. McDougall, Atlanta; Thomas E. Averitt, Thomson; Luther J. Smith, Columbus; Ellis B. Keener, Decatur.

REFERENCE COMMITTEE C: Virgle W. McEver, Jr., Warner Robins, Chairman; Clyde A. Burgamy, Augusta, Vice Chairman; Alexander W. Ashford, Monroe; Jack Hirsch, Columbus; Charles E. Todd, Atlanta; C. Roy Williams, Wadley.

REFERENCE COMMITTEE D: Menard Ihnen, Augusta, Chairman; Bill Purcell, Calhoun, Vice Chairman; F. Debele Maner, Savannah; Joseph S. Wilson, Atlanta; J. Emmett Collins, Manchester; C. A. Wilson, Brunswick.

REFERENCE COMMITTEE E: Frank L. Wilson, Jr., Atlanta, Chairman; E. H. Giles, Blakely, Vice Chairman; Henry C. Drake, Macon; James Skinner, Griffin; Frank R. Mann, McRae; Jack R. Meacham, Summerville.

To expedite the reading and adoption of the minutes of the 1969 Sessions of the House of Delegates held in conjunction with the 115th Annual Session of the Medical Association of Georgia, convened on May 5 and 7, 1969, at the Savannah Inn and Country Club, Savannah, Georgia, the Chair entertained a motion that the minutes, as published in the June 1969 Issue of the *Journal of the Medical Association of Georgia*, be approved. On motion duly made and seconded, it was voted that these minutes be so approved as published in their entirety in the June 1969 issue of the *JMAG*.

Speaker Rogers then recognized Dr. F. William Dowda, MAG Second Vice President, for the purpose of introducing two distinguished guests. Dr. Dowda then introduced Mr. Jack Ray, Treasurer of the State of Georgia, and Mr. Alfa Fowler, Member of the Georgia Public Service Commission, both of whom brought brief remarks to the House of Delegates.

Nominations

Speaker Rogers then reminded the House that a change in the Bylaws of the Medical Association of Georgia, adopted in 1969, directed that the General Officers of the Association, Delegates and Alternates to the American Medical Association House of Delegates were to be elected by the MAG House of Delegates and called for nominations from the Floor for the Association's officers, with the following nominations being made: President-Elect—William C. Mitchell, Smyrna, nominated by Remer Y.

Clark; seconded by Charles R. Andrews, Jr., F. William Dowda and Braswell E. Collins.

There being no other nominations for the office of President-Elect, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then reminded the Delegates that the Second Vice President automatically exceeds to the office of First Vice President, thereby obviating the need to nominate a First Vice President. Speaker Rogers announced that the First Vice President for 1970-71 would be F. William Dowda, of Atlanta.

Henry D. Scoggins, Augusta, was nominated for the office of Second Vice President by Preston D. Ellington, Augusta; seconded by Joe C. Stubbs, Valdosta, Thomas A. Montgomery, Athens and Braswell E. Collins.

There being no further nominations for the office of Second Vice President, on motion duly made and seconded, the nominations were closed.

Speaker Rogers then noted that in accordance with MAG Bylaws, as revised in 1966, under Chapter V, Section 2, Nominations, it is stated that if a District Society or a component County Medical Society is entitled to direct representation by one or more Councilors and Vice Councilors, the Secretary of the MAG must receive no later than 15 days before the Annual Session, written notice of the election of Councilors and Vice Councilors, that these Councilors and Vice Councilors may be considered by the Association as duly elected, and nominations from the floor are only to be accepted in the absence of such notification of election to the Secretary of the MAG 15 days in advance of an Annual Session.

Speaker Rogers stated that he was happy to report that the District and County Medical Societies whose Councilors' and Vice Councilors' terms of office had expired had duly notified MAG of their elections and no nominations from the Floor were then in order.

Dr. Rogers then read the notification of these elections as received by the MAG from the Secretary of the respective District and County Medical Societies as follows:

First District Councilor—C. Emory Bohler, Brooklet, 1970-73

First District Vice Councilor—J. Roy Rowland, Jr., Dublin, 1970-73

Second District Councilor—J. D. Bateman, Albany, 1970-73

Second District Vice Councilor—Donald J. McKenzie, Thomasville, 1970-73

Third District Councilor—J. T. Christmas, Vienna, 1970-73

Third District Vice Councilor—John H. Robinson, Americus, 1970-73

Fulton County Councilor—J. Harold Harrison, Atlanta, 1970-73

Fulton County Vice Councilor—William W. Moore, Atlanta, 1970-73

Georgia Medical Society Councilor—L. R. Lanier, Jr., Savannah, 1970-73

Georgia Medical Society Vice Councilor—L. S. Bodziner, Savannah, 1970-73

Speaker Rogers then stated that the MAG had been notified by the President of the Eighth District that upon resignation of President-Elect F. G. Eldridge, the Eighth District had elected Robert E. Perry, Brunswick, as Councilor and Joe C. Stubbs, Valdosta, as Vice Councilor to serve out the terms of Councilor and Vice Councilor expiring in 1971.

AMA Delegates

Speaker Rogers then called for nominations for MAG Delegates to the American Medical Association and stated that he would identify the elective posts by announcing the name of the incumbent in office and also giving the term of office.

AMA Delegate (for the Office held by J. Frank Walker, of Atlanta; the term beginning January 1, 1971 and expiring December 31, 1972)—J. Frank Walker, Atlanta, nominated by J. Rhodes Haverty; seconded by Donald R. Rooney.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Delegate (for the Office held by Preston D. Ellington, of Augusta; the term beginning January 1, 1971 and expiring December 31, 1972)—Preston D. Ellington, Augusta, nominated by Ronald F. Galloway; seconded by Henry Tift.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

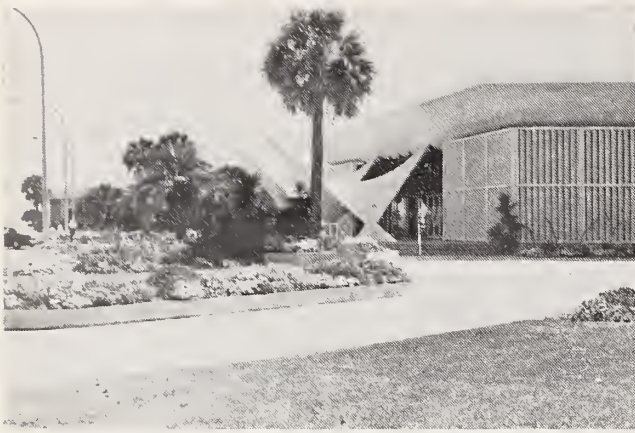
AMA Alternate Delegate (for the Office held by J. D. Bateman, of Albany; the term beginning January 1, 1971 and expiring December 31, 1972)—J. D. Bateman, Albany, nominated by Charles D. Hollis, Jr. and seconded by John Schellack.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

AMA Alternate Delegate (for the Office held by F. W. Dowda, of Atlanta; the term beginning January 1, 1971 and expiring December 31, 1972)—F. W. Dowda, Atlanta, nominated by Edwin C. Evans; seconded by Charles Burton, Luther M. Vinton and A. F. Williams.

There being no further nominations, on motion duly made and seconded, it was voted to close the nominations.

Speaker Rogers then announced that the voting



Jekyll Island Aquarama, and MAG Convention Center.

would take place on official MAG Ballots at the Second Session of the House of Delegates, to be convened on Sunday, May 10.

General Practitioner of the Year Award

Speaker Rogers then stated that he wished to announce that the election of the General Practitioner of the Year Award would be held during this First Session of the House of Delegates. Speaker Rogers called attention to the nomination for this high honor which was included in the Delegates Handbook and stated that it had been officially received at least two weeks in advance. Dr. Rogers then announced the official nominee for 1970 General Practitioner of the Year was Walter Edward Brown, of Savannah, and called for a vote by asking the House of Delegates to stand.

Speaker Rogers then introduced Dr. Tom Sappington, of Thomaston, President of the Georgia Academy of General Practice, who presented Dr. Brown with the General Practitioner of the Year Award.

Speaker Rogers then called for the Annual Reports of Officers, Council, Councilors and Vice Councilors, AMA Delegates, Association Committees and Other Reports as introduced at this Session, which are listed below with the appropriate Reference Committee indicated for those reports which were referred. The full Report; the action of appropriate Reference Committees, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates on those reports and resolutions which were referred to Reference Committees. (See Pages 229 to 266.)

OFFICERS

President—Not Referred
 President-Elect—Not Referred
 Past President—Not Referred
 First Vice President—Reference Committee B
 Second Vice President—Reference Committee D
 Secretary—Not Referred

Treasurer—Not Referred
 Speaker of the House—Reference Committee A
 Vice Speaker of the House—Reference Committee A
 AMA Alternate Delegate (Dowda)—Reference Committee C

COUNCILORS AND VICE COUNCILORS

Chairman of Council—Reference Committee B
 First District Councilor—Not Referred
 Second District Councilor—Not Referred
 Third District Councilor—Not Referred
 Sixth District Councilor—Not Referred
 Seventh District Vice Councilor—Not Referred
 Eighth District Councilor—Not Referred
 Ninth District Councilor—Not Referred
 Tenth District Councilor—Not Referred
 Bibb County Medical Society Councilor—Not Referred
 Bibb County Medical Society Vice Councilor—Not Referred
 Cobb County Medical Society Councilor—Reference Committee E
 DeKalb County Medical Society Councilor and Vice Councilor—Not Referred
 Fulton County Medical Society Councilor (Jolley)—Reference Committee B
 Fulton County Medical Society Councilor (Godwin)—Not Referred
 Georgia Medical Society Councilor—Not Referred
 Muscogee County Medical Society Councilor—Not Referred
 Richmond County Medical Society Councilor—Not Referred

ASSOCIATION COMMITTEES

Annual Session—Not Referred
 Constitution and Bylaws—Reference Committee C
 Finance—Not Referred
 Professional Conduct and Medical Ethics—Not Referred
 Emergency Medical Services—Reference Committee E
 Woman's Auxiliary Advisory—Reference Committee A
 Allied Health Careers—Reference Committee B
 Areawide Health Planning—Reference Committee B
 Blood Banks—Not Referred
 Cancer—Reference Committee D
 Disaster Medical Care—Not Referred
 Governmental Medical Services—Not Referred
 Historical—Not Referred
 Insurance and Economics—Reference Committee D
 Legislation
 National—Reference Committee C
 State—Reference Committee C
 Maternal and Infant Welfare—Reference Committee A
 Medical Education—Reference Committee B
 Medical Review and Negotiating—Reference Committee D
 Medicine and Religion—Not Referred
 Mental Health—Not Referred
 Nursing Liaison—Reference Committee A
 Occupational Health—Reference Committee C

Physician Lawyer Liaison—Reference Committee C
Public Service—Reference Committee E
Rural Health—Not Referred
School Child Health—Reference Committee E
Separate Billing—Not Referred

SPECIAL REPORTS

Report of the *Journal*—Not Referred
Woman's Auxiliary to the Medical Association of Georgia—Not Referred
Georgia Regional Medical Program—Not Referred
Operational Projects, Georgia Regional Medical Program—Not Referred

Speaker Rogers then called attention to reports which were shown as "Not Referred" and stated that these were excellent reports containing information on projects and activities in progress or already completed. Speaker Rogers then recognized President John Kirk Train, Jr., for the purpose of a motion regarding those reports "Not Referred."

President

JOHN KIRK TRAIN, M.D., *Savannah*

Ours is a dedicated profession. From our ranks in Georgia come physicians who guide the destiny of health care in this state and nation. It has been my greatest personal desire this past year to see brought to conclusion some of the many programs begun during the administration of my predecessor, Charlie Andrews, and to stimulate and participate in the many worthwhile MAG activities. Our organization has continued to exert powerful influence over the direction of health care delivery in Georgia, and it has been my privilege and a distinct honor to serve as its President. My sincere appreciation for having this opportunity can never be fully expressed.

As President, it has been my privilege to preside over all meetings of the Executive Committee of Council and to attend all Council meetings. In mentioning Council meetings it seems appropriate to comment on the propriety of Council's meeting outside the boundaries of the state of Georgia, and to express my wholehearted support for this activity. The March meeting of the Council, held at the San Jeronimo Hilton, in San Juan, Puerto Rico, was a most productive session resulting from the relaxing atmosphere not possibly found in the state at that time of the year. May Council continue this worthwhile and enjoyable precedent.

It was also my privilege to attend both meetings of the American Medical Association and actively participate as a member of the Georgia delegation at the AMA Public Affairs Workshop in Washington, D.C., and the MAG luncheon with Georgia Senators and Congressmen, the County Medical Society Officers Conference, the Second Georgia Conference on Peer Review and the Committee Conclave.

Two distinct but related items deserve special note in any report on the Year 1969-70. Most significant is the completion of MAG's first building project. It is truly a most beautiful and functional facility which not only meets our present needs from a utilitarian viewpoint, but also reflects the position of influence which

MAG occupies in Georgia. I urge every member to view and enjoy this tangible evidence of our growth. Also worthy of special mention is the \$100 additional dues imposed by the House of Delegates but left to the officers to administer. A minimum of problems were created by this action, while a great majority of the membership trusted in the wisdom and judgment of the House, and responded to the billing without audible question.

Few of you will ever know the true depth of pride I have in you, my colleagues and the staff. I have mentioned before how invaluable our able staff at MAG headquarters is and has been, and if I were not afraid that whatever more I said would turn their heads and puff them up unseemingly, I would say more. Suffice it to say that without the aid and assistance of all our staff in our programming and the carrying out of our programs, MAG would not be the active organization that it is. I will now have the satisfaction of seeing new officers selected and responsibilities passed on to them. I know that they will take their places loyally and I pledge my support to them as I have received it from each of you.

President-Elect

F. G. ELDRIDGE, M.D., *Valdosta*

As President-Elect of the Medical Association of Georgia for the past year, I have carried out the privilege and duty of attending the quarterly Council meetings and the monthly meetings of the Executive Committee of the Association. Parenthetically, I should comment here that I did miss a portion of one quarterly Council Meeting because it conflicted with a football game in Valdosta, and it is well known that no self-respecting Valdostan would dare miss a meeting of the Wildcats in Death Valley.

I also attended the Annual Meeting of the A.M.A. in New York in July, 1969, and also the Clinical Session in Denver in December.

To prevent repetition, recommendations by your President-Elect will be embodied in the address to be given on Thursday, May 7, 1970 at the first General Session of the Association.

Past President

WALTER BROWN, M.D., *Savannah*

This will be my last annual report. For my many friends, associates and contacts from my association with MAG and organized medicine on State and National level, I am privileged and grateful.

These have been my most rewarding years in every way, and I hope that I might still be able to contribute to the furtherance of our aims and activities for the future of medicine in America as we see it, and not as what is being and will be projected by bureaucratic and governmental agencies for our profession, and directed methods of care and treatment for the ill and aged.

I feel that these many problems facing us should be primarily in the hands of our younger members, with advice and counseling from those of us now older, when solicited and invited. I, therefore, do not bring any specific recommendations to the House of Delegates.

Secretary

JOHN RHODES HAVERTY, M.D., *Atlanta*

This marks the end of the first year of my second term as your Secretary. I would like to thank this House for its vote of confidence by re-electing me to a second three-year term of office. During this past year, I have continued to carry out those duties delegated to me by our Constitution, this House of Delegates, and the Executive Committee in those areas assigned to the office of Secretary. The duties of this office have been made immeasurably easier by the excellent quality and helpful cooperation of the members of our Headquarter's staff, headed so ably by Mr. Edwin F. Smith. Under his leadership, the MAG operating policies and study of staff personnel were analyzed in depth and a new set of guidelines and job descriptions prepared. These were adopted with some minor changes by the Executive Committee in October, 1969.

1969 MEMBERSHIP REPORT

Active	3,153
DE-1	30
DE-2	49
DE-3	54
DE-4	27
Life	181
Associate	68
Service	59
Honorary	1
Affiliate	1
Total	3,623

Georgia Regional Medical Program

One of the founders of the Georgia Regional Medical Program, Dr. J. W. Chambers, resigned as Coordinator for the Medical Association of Georgia during

this past year. The gratitude of every physician in Georgia, as well as the patients who will benefit from this program, is due Dr. Chambers for his leadership in this program. With the guidance of Dr. Chambers and of our Director, Dr. J. Gordon Barrow, we have achieved in Georgia a state of cooperation and success with a governmental program that I have not heard equalled throughout the United States. Georgia constantly is being commended and copied as a leader in organized medicine. Naturally, all of us were saddened to have Dr. Chambers step down from this post. The blow was softened greatly, however, by the acceptance of the position as Coordinator by Dr. George Alexander of Forsyth. More than anyone else in the state, with the exception of Dr. Chambers, Dr. Alexander is responsible for the achievements of this program, for he was President of MAG when successful negotiations making MAG the grantee of this important program were concluded. We are fortunate indeed in having two such capable members of this Association who are willing to assume this task.

As Fiscal Agent of this program, I can assure you that financial affairs of the program within our State are in good order. The health aspects of the program continue to expand under the leadership of Dr. Barrow and with the advice of numerous members of the Medical Association of Georgia. I have been honored during this past year to be elected Chairman of the Regional Advisory Group of the GRMP.

MAG Foundation

The MAG Foundation has continued to expand, both in interest throughout the state and financially. Presently, we are administering the William R. Dancey, M.D., Foundation funds which loans money to needy medical students. Several other such worthwhile projects are being considered for the Foundation by various organizations. A new set of officers, and a new Trustee have been named for the year 1970. They are as follows:

1969 OCHAMPUS Statistical Report

Number of Claims	Annual		% Total		Avg/Month		Avg/Day	
	'69	'68	'69	'68	'69	'68	'69	'68
Received	40,183*	37,320	100	100	3,348	3,110	157	145
Returned	8,358	8,065	21	22	696	672	33	31
Rejected	2,087	1,754	5	5	173	146	8	6
Adjusted	3,773	3,753	9	9.5	314	269	15	13
Adjudicated (Review)	5	59		.1				
Paid Reg.	25,379		63		2,115		99	
Drugs	1,991		5		166		8	
† Total	27,370	29,432	68	80	2,281	2,452	107	114
			'69		'68			
Total Dollar Amount Paid			\$2,684,855.72		\$2,502,695.08			
Average Per Claim			105.79					
			(Reg. and Handicap) †					
			29.04					
			(Drugs)					

* Includes both regular claims and drugs.

† Represents increase of \$20.76 per claim over 1968 (24 per cent). Last year's report included drugs with regular program which would have reduced average per claim. Therefore, this 24 per cent is not entirely accurate.

‡ The lower total claims paid (and the lower percentage paid) in 1969 than in 1968 reflects a backlog of claims still to be paid after Dec. 31, 1969. This backlog primarily is due to personnel changes in the OCHAMPUS office.

1970 MAG Foundation Trustees

Charles R. Andrews, Jr., M.D., President, Canton, Georgia 30114—Term Expires December, 1971

Harry D. Pinson, M.D., Vice-President, 1467 Harper Street, Augusta, Georgia 30902—Term Expires December, 1972

John T. Mauldin, M.D., Secretary-Treasurer, 401 Peachtree Street, N.E., Atlanta, Georgia 30308—Term Expires December, 1973

J. Frank Walker, M.D., 1293 Peachtree Street, N.E., Atlanta, Georgia 30309—Term Expires December, 1974

J. Rhodes Haverty, M.D., 33 Gilmer Street, S.E., Atlanta, Georgia 30303—Term Expires December, 1970

(Plus an additional trustee to be named at a later date.)

A number of things have happened to our Association during the past year which are novel or different. One of the most important, of course, is our occupation of our new headquarters office. It is ample and beautiful. We welcome all who wish to see it, and are proud to show it off. Every member of this House can be proud of his part in accomplishing the needed goal of the expansion of our physical facilities. It has been done on a fiscally sound basis and will stand us in good stead for years to come.

It is certainly obvious to all of us at this meeting of our Annual Session, that the revamping of the format of the Annual Session has been thought out carefully and well, and the results are appreciated by us all. Dr. Preston Ellington deserves a real vote of thanks, and it is anticipated that more participation by more physicians within the Association can be expected because of his work.

A new field service representative, Mr. Carl Bailey, has been received graciously and gratefully by the various districts and county societies of our state. He has done a fine job, enjoys his work, and is a welcome and useful addition to our staff.

Dr. Frank Walker, who needs no introduction to this House, now finds himself officiating alternately

with Dr. Russell Roth of Pennsylvania, in the AMA House of Delegates as its Vice Speaker. Frank did an exemplary job, as we all knew he would, during the AMA Meeting in Denver in November, 1969.

One of the biggest changes from former years, with its impact yet to be felt in great measure, is our change of fiscal year from its previous time to a June 1-May 31 year. It is anticipated that many services to our members will be facilitated by this change, and that the business of this House can be made easier. The House will be able to have more available information on which to base its decisions now than in the past.

Again, may I assure you it is a privilege to serve as your Secretary, and I look forward to another exciting year in the Medical Association of Georgia.

ERNST & ERNST

FIRST NATIONAL BANK BUILDING

ATLANTA, GA. 30303

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of the funds of The Medical Association of Georgia as of December 31, 1969, and the related statements of income and expenses and fund equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. While it was not practicable to confirm the amount due from the United States Government with respect to the balance due under the Medicare contract, we have satisfied ourselves as to this balance by means of other auditing procedures.

In our opinion, the accompanying statement of assets and liabilities and the statements of income and expenses and fund equities present fairly the financial position of the funds of The Medical Association of Georgia at December 31, 1969, and the results of their operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Atlanta, Georgia
April 2, 1970

STATEMENT OF ASSETS AND LIABILITIES—BY FUNDS THE MEDICAL ASSOCIATION OF GEORGIA

December 31, 1969

ASSETS

GENERAL FUND

Cash:			
Demand deposits		\$ 7,198.58	
Savings deposits:			
Restricted	\$ 35,077.39		
Unrestricted	270,000.00	305,077.39	\$ 312,275.97
Accounts receivable:			
Advertisers of <i>The Journal</i>		\$ 2,711.70	
Due from National Cancer Institute		18,843.78	
Due from Georgia Regional Medical Program		246.91	
Excess of claim expenses incurred over claim fees received:			
United States Government—Medicare		51,189.50	
Georgia Regional Medical Program		9,284.78	82,276.67
Other assets			625.00

ASSETS AND LIABILITIES—Continued

Property and equipment—on the basis of cost—Note A:		
Building—old	\$ 90,954.72	
Building—new	666,534.36	
Furniture and equipment	40,231.69	
	<u>\$797,720.77</u>	
Less allowances for depreciation	78,180.61	
	<u>\$719,540.16</u>	
Land	80,000.00	799,540.16
		<u>\$1,194,717.80</u>
ABNER W. CALHOUN LECTURESHIP FUND		
Cash	\$ 132.96	
Corporation stocks (quoted market prices \$3,418.00)—at cost ..	5,897.03	6,029.99
		<u>\$1,200,747.79</u>

LIABILITIES AND EQUITIES

GENERAL FUND

Liabilities:		
Note Payable—Note A		\$ 547,072.41
Accounts payable—trade		11,279.74
Excess of fees received over expenses—National Cancer Institute		192.85
Advances from Georgia Chapter—American Cancer Society ..		10,000.00
Advances from Emory University Hospital		10,000.00
Retirement funds		8,123.90
Advance collections:		
1970 membership dues	\$ 33,867.00	
1970 exhibit space payments	2,700.00	36,567.00
Fund equity:		
Restricted:		
Regular operating purposes	\$ 20,000.00	
Lecture expenses	1,010.76	
	<u>\$ 21,010.76</u>	
Unrestricted	550,471.14	571,481.90
		<u>\$1,194,717.80</u>
ABNER W. CALHOUN LECTURESHIP FUND EQUITY		6,029.99
		<u>\$1,200,747.79</u>

See Notes to Financial Statements.

STATEMENT OF FUND EQUITIES

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1969

	Balance Jan. 1, 1969	Excess of Income Over Expenses	Fund Transfers	Balance Dec. 31, 1969
GENERAL FUND				
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses	786.94	-0-	223.82	1,010.76
Unrestricted	265,440.73	285,030.41	-0-	550,471.14
	<u>\$286,227.67</u>	<u>\$285,030.41</u>	<u>\$223.82</u>	<u>\$571,481.90</u>
ABNER W. CALHOUN LECTURESHIP FUND	6,029.99	223.82	223.82*	6,029.99
TOTAL	<u>\$292,257.66</u>	<u>\$285,254.23</u>	<u>\$ -0-</u>	<u>\$577,511.89</u>

* Indicates red figure.

See Notes to Financial Statements.

STATEMENT OF INCOME AND EXPENSES—BY FUNDS

THE MEDICAL ASSOCIATION OF GEORGIA

Year ended December 31, 1969

	General Fund	Abner W. Calhoun Lectureship Fund
INCOME		
Medical Association of Georgia dues	\$127,740.00	\$ -0-
Additional dues	275,400.00	-0-
Advertising— <i>The Journal</i>	44,679.62	-0-
Subscriptions— <i>The Journal</i>	1,622.35	-0-
Exhibitors fees—1969 annual meeting	7,150.00	-0-
Interest income	12,629.28	-0-
Dividends—corporate stocks	-0-	261.92
American Medical Association refund	2,105.70	-0-
Miscellaneous	106.31	-0-
TOTAL INCOME	471,433.26	261.92
EXPENSES		
Fixed allotments	38,649.88	-0-
Association office	136,295.12	-0-
Association boards	18,672.20	-0-
Related Association activities	3,858.58	-0-
Contingent fund	2,794.48	-0-
<i>The Journal</i>	45,196.74	-0-
Trustees fees and expenses	-0-	38.10
Recovered expenses	59,064.15*	-0-
TOTAL EXPENSES	186,402.85	38.10
EXCESS OF INCOME OVER EXPENSES	\$285,030.41	\$223.82

* Indicates red figure.
See Notes to Financial Statements.

NOTES TO FINANCIAL STATEMENTS

THE MEDICAL ASSOCIATION OF GEORGIA

December 31, 1969

Note A—Property and Note Payable

The note payable is a 7½ per cent mortgage payable \$4,541 monthly (including principal and interest) until 1987. The land and buildings have been pledged as collateral for the loan.

Depreciation is computed on the straight-line method and amounted to \$8,887 for the year 1969 and \$6,707 for the year 1968.

Note B—Retirement Plan

The Association has a non-contributory retirement plan for all employees with two years or more service. The cost of this plan was \$4,088 in 1969 and \$2,565 in 1968. There is no past service cost and it is the Association's policy to fund all costs as incurred. In addition, during 1969 the Association also charged income for \$8,124 to provide additional retirement benefits for certain employees.

Note C—Funds Administrated by the Association

The financial statements do not include the assets, liabilities, and results of operations of (1) the Georgia Regional Medical Program, (2) CHAMPUS, or (3) the Third National Cancer Survey. These programs are administered by the Association under grants from various United States Government agencies.

First District Councilor

CHARLES E. BOHLER, M.D., *Brooklet*

As Councilor of First District I have attended all council meetings during the year-annual.

The meeting of the First District Medical Society will be held at the Holiday Inn in Statesboro on April 15.

During the year, the Jenkins County Medical Society and the Liberty County Medical Society have surrendered their charters because of insufficient membership.

The Jenkins County Medical Society merged with Bulloch-Candler-Evans and became the Ogeechee River Medical Society.

The Liberty County Medical Society members joined the Georgia Medical Society.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Ogeechee River				
Charles Richardson				
Statesboro	22	20	22	21
Burke				
C. G. Green, Sr.				
Waynesboro	7	5	9	5
Emanuel				
Robert J. Moye				
Swainsboro	7	5	9	7
Laurens				
Grady E. Longino				
Dublin	41	21	42	20
Screven				
William G. Simmons				
Sylvania	5	5	5	5
Southeast Georgia				
G. P. Sassos				
Mount Vernon	21	14	23	16
Tri-County*			2	2
	103	70	112	76

* Tri-County has merged with Georgia Medical.

Second District Councilor

J. D. BATEMAN, M.D., *Albany*

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Colquitt				
Robert E. Fokes, Jr.				
Moultrie	16	13	16	14
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	16	8	17	9
Dougherty				
Prentiss E. Findlay				
Albany	60	49	60	47



Robert E. Wells, M.D. (left), Joseph H. Dimon, M.D., and J. Frank Walker, M.D., in informal deliberation during Annual Session.

Grady*

C. K. Singleton				
Cairo			5	4
Mitchell				
A. A. McNeill, Jr.				
Camilla	7	7	6	6
Southwest Georgia				
Eugene Giles				
Blakely	12	10	12	10
Thomas-Brooks-Grady				
Frank G. Osborne				
Thomasville	53	44	46	41
Tift				
Don Smith				
Tifton	17	12	17	12
Worth				
R. T. Morgan				
Sylvester	5	5	5	5
	186	148	184	148

* Grady has merged with Thomas-Brooks.

Third District Councilor

J. T. CHRISTMAS, M.D., *Vienna*

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Flint				
R. E. Barr				
Cordele	16	14	17	14
Peach Belt				
Johann R. Manning				
Warner Robins	34	32	35	33
Randolph-Stewart-Terrell				
John G. Bates				
Cuthbert	12	11	14	11
Sumter				
William R. Anderson				
Americus	26	20	22	18
Taylor*			3	2
	88	77	91	78

* Taylor has merged with Sumter.

Sixth District Councilor

ERNEST E. PROCTOR, M.D., *Newnan*

Since the last Annual Session of the Medical Association of Georgia, the Sixth District Medical Society has remained active, holding quarterly meetings in circuit fashion through the larger counties in the district. At all of these meetings programs of considerable interest have been presented. The content of the programs has generally been non-scientific. Unfortunately, attendance at Sixth District Society meetings has been less than 50 per cent in spite of the efforts of the Bibb County Councilor, the Sixth District Councilor, the immediate past President, and the current President of the Sixth District Medical Society and all Secretaries serving during this period of time to correct this poor attendance record.

During the past year, the Lamar County Medical Society has forfeited its charter because of an insufficient number of dues-paying members. Arrangements have been made for merger with Spalding County Medical Society.

There has been a slight increase in the number of members of the Medical Association of Georgia throughout the district (exclusive of Bibb County) during the past months as the membership figures below indicate.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Clayton-Fayette F. A. Sams, Jr. Fayetteville	8	7	8	8
Coweta Thomas C. Graham Newnan	22	14	23	14
Lamar*			4	4
Meriwether-Harris J. L. Robinson Woodbury	15	13	14	12
Spalding Robert Proctor Griffin	44	39	41	36
Troup Stevens Byars LaGrange	40	35	37	31
Upson Joel E. Mikell Thomaston	19	16	18	15
	148	124	145	120

* Lamar has merged with Spalding.

Seventh District Councilor

DAVID A. WELLS, M.D., *Dalton*

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bartow W. C. Holmes Cartersville	10	6	10	6

Carroll-Douglas-Haralson

E. H. Grant Carrollton	38	36	35	33
Floyd Tom Moss, Jr. Rome	85	76	83	72
Gordon Joseph A. Bishop Calhoun	9	8	9	8
Polk Harold Goldin Rockmart	14	12	14	12
Walker-Catoosa-Dade Garland E. Kinard Rossville	35	20	32	19
Whitfield Paul E. Henson Dalton	40	36	38	33
	231	194	221	183

Eighth District Councilor

ROBERT E. PERRY, JR., M.D., *Brunswick*

Having been elevated to the position of Councilor following the election of Dr. Frank Eldridge to the office of President-Elect, I have devoted my time to learning the operations of this group.

Council meetings have been attended with participation in the decisions made by this body. Close liaison with the Vice Councilor has been maintained as well as personal efforts to secure the payment of the extra 1969 dues.

At this time neither I nor the Vice Councilor have any recommendations to be placed before the House for their consideration.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Altamaha H. L. Morgan Baxley	7	7	7	7
Ben Hill-Irwin Morgan Smith Fitzgerald	8	8	8	8
Coffee John W. Herndon Douglas	10	7	10	7
Camden-Charlton H. H. Robinson Kingsland	10	7	11	7
Glynn Hurley Jones Brunswick	46	43	47	42
Ocmulgee W. E. Coleman Hawkinsville	16	13	15	11
South Georgia John Nelson Valdosta	58	43	62	47

Telfair				
D. B. McRae				
McRae	5	4	5	4
Ware				
Edward Brown				
Waycross	43	40	42	40
Wayne				
E. L. Harrell				
Jesup	9	9	9	9
	212	181	215	181

Ninth District Councilor

P. T. SCOGGINS, M.D., *Commerce*

NINTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Barrow				
R. F. Graves				
Winder	8	7	8	7
Blue Ridge				
H. E. Mitzelfelt				
Blue Ridge	6	5	6	5
Chattahoochee				
Rupert Bramblett				
Cumming	21	16	22	15
Cherokee-Pickens				
James C. Cooper				
Woodstock	14	13	16	13
Elbert-Franklin-Hart				
Robert Sullivan				
Carnesville	19	10	22	13
Habersham				
J. B. Edwards				
Cornelia	18	14	14	10
Hall				
James Burns				
Gainesville	63	58	63	58
Jackson-Banks				
Samuel Vickery				
Commerce	10	7	10	7
Rabun*			4	4
Stephens				
Kenneth Conoley				
Toccoa	21	20	18	17
	180	150	183	149

* Rabun has merged with Habersham.

Tenth District Councilor

EDWIN W. ALLEN, JR., M.D., *Milledgeville*

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Baldwin				
L. J. Jacobs				
Milledgeville	38	31	32	24

Crawford W. Long				
Golden S. Hinton				
Athens	68	52	65	49
Jasper*			3	3
Jefferson				
C. Roy Williams				
Wadley	5	4	5	4
McDuffie				
Thomas E. Averitt				
Thomson	7	6	7	7
Newton-Rockdale				
E. J. Callaway				
Covington	12	7	13	7
Oconee Valley				
L. J. Wade				
Union Point	11	8	11	8
Walton				
Robert M. Tankesley				
Monroe	10	9	11	9
Washington				
William Taylor				
Tennille	10	2	11	1
Wilkes				
A. D. Duggan				
Washington	6	5	6	5
	167	124	164	117

* Jasper has merged with Baldwin.

Bibb County Medical Society Councilor

BRASWELL E. COLLINS, M.D., *Macon*

The following report is submitted from the Bibb County Medical Society Councilor to the Medical Association of Georgia.

The Bibb County Medical Society has maintained an active membership of 184. Monthly meetings have averaged an 80 per cent attendance.

The Bibb County Medical Society conducted a city wide "Glaucoma Survey" in cooperation with the Georgia Chapter of the National Society for the Prevention of Blindness.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Bibb				
Lil James				
Macon	184	153	185	153



The House of Delegates efficiently disposed of the business before it, ignoring the lure of the sea.

Bibb County Medical Society Vice-Councilor

MILTON I. JOHNSON, JR., M.D., *Macon*

The Vice-Councilor took office in May of 1969 and since that time has attended meetings of the Council held at Sea Island and in Atlanta and serves on the Insurance Committee of Council.

During this time I have enjoyed guidance from our Councilor, Dr. Braswell E. Collins and tried to familiarize myself with the workings of the Council. It is most impressive to observe the quality of men who serve as Councilors and their dedication to the profession of medicine. It would be my wish that those who feel that the Medical Association of Georgia does little for them would attend just one meeting of the Council. I am sure that they would not fail to be impressed favorably.

The Bibb County Medical Society has enjoyed a fruitful and interesting year. Meeting attendance has been excellent and the programs have been most worthwhile.

DeKalb County Medical Society Councilor and Vice-Councilor

FLOYD R. SANDERS, JR., M.D., *Councilor*, and
M. F. SIMMONS, M.D., *Vice-Councilor*

During the past year it has been our privilege to represent the DeKalb County Medical Society at all regular meetings of Council.

The medical society continues to attract new members in all areas of medical care, but the supply of physicians continues to lag behind the demand. Daily requests to the society office for medical help from new and long time residents of the community constantly go unfulfilled. Consequently more and more patients are going to the hospital emergency room for help, and the DeKalb Emergency Group is being called on to bridge this gap. As a result, non-emergency patients are making it more difficult to handle the true emergency. This situation is not limited to our community alone, but seems to be worse in urban areas. Perhaps a more concerted effort on the part of organized medicine toward the better education of the general public as to the proper use of emergency room facilities would be worthwhile.

FOURTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
DeKalb				
S. Angier Wills				
Decatur	213	194	197	180

Fulton County Medical Society Councilor

JOHN T. GODWIN, M.D., *Atlanta*

All meetings have been attended with the exception of one during the reporting.

The meetings have been provocative and stimulating. There are no recommendations at this time.

Georgia Medical Society Councilor

LEE HOWARD, JR., M.D., *Savannah*

Again I would like to commend all MAG officers and members of Council for their dedication in carrying on the business of the MAG during the year.

I have no recommendations to be placed before the House of Delegates.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Georgia Medical Society				
Harry H. McGee				
Savannah	170	152	171	156

Muscogee County Medical Society Councilor

ROY L. GIBSON, M.D., *Columbus*

As Councilor of the Muscogee County Medical Society to the Medical Association of Georgia I have regularly attended the meetings of Council and reported back to the members of my Society on the action of Council.

During the past year this Society had eight regular meetings with programs as follows:

January—Dr. Ross Neisuler, "The Georgia Efforts in Population Control"

February—Mr. Scott Donovan, Medical College of Georgia, "New Horizons in Continuing Education for the Physician"

March—Joint Meeting with the Columbus Lawyers Club—Mr. Peyton Hawes, Revenue Commissioner, Guest Speaker

April—A Symposium on Medicine and Surgery—All Day Program at which we hosted the Third District Medical Society Guest Speakers—Dr. Isadore Dyer, Dr. John Braasch, Dr. Perry MacNeal

May—Dr. Paul G. McDonough, Associate Professor Obstetrics and Gynecology, Medical College of Georgia, "Medical, Moral and Legal Aspects of Therapeutic Abortion"

September—Joint Meeting with the Medical Staff of the Martin Army Hospital, Ft. Benning, Ga.—Dr. William F. Josey, Assistant Professor, Dept. of Obstetrics and Gynecology, Emory University School of Medicine, "Present Knowledge of Viral Pelvic Infections"

October—Program on the Society's Disability Income Insurance

November—Annual Meeting and Election of Officers

During the past year the members of this Society worked with the American Cancer Society on a program called "Conquer Uterine Cancer in Muscogee County." The film "Time and Two Women" was shown to women residents of all local housing projects. Afterwards a free "Pap" test was done by a local physician. Medical facilities were set up in a mobile home which was made available by the local Mobile Home Dealers Association. Four hundred women saw the film and 250 Pap Smears were done with three of these positive.

Members of this society also worked with the local Diabetes Detection Drive.

Community Health Week was held here in Columbus October 19-25 with members of the Auxiliary working with the society on this project.

The majority of the members of this society paid the additional \$100 dues voted by the House of Delegates.

Members of this society worked with the local Charter Commission on plans for a Medical Examiner System for this county.

A Rubella Vaccination Program was held in this county and directed by our local health department.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Muscogee				
Donald M. Stewart				
Columbus	127	113	127	113

Richmond County Medical Society Councilor

J. L. MULHERIN, M.D., Augusta

During the past year, I have attended all the meetings of Council with the exception of the March meeting held in Puerto Rico.

The most controversial problem as far as the Richmond County Medical Society was concerned was the additional dues of \$100.00 for 1969 which was passed by the House of Delegates in Savannah, Ga. This created a good bit of ill-will with some of our members and many were real critical of the action of the House. With the aid of our Vice-Councilor and Officers of the Richmond County Medical Society, each delinquent member was contacted and the response was gratifying although we still have some who have not paid the additional dues and a couple of members who simply refuse to pay.

I have no specific recommendations to make at this time but would like to take this opportunity to thank the staff of the Medical Association of Georgia for their loyal and dedicated work during the past year.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Richmond				
C. Stephen Mulherin				
Augusta	292	250	280	250

Annual Session Committee

PRESTON D. ELLINGTON, M.D., Chairman

The Committee on Annual Session of the Medical Association of Georgia wishes to express sincere thanks to all those members of the Association, to all those members of the Auxiliary, to the members of the Local Arrangements Committee, and especially to the MAG Headquarters Staff for all their help in making this meeting possible.

This year the Committee has again worked to improve various areas of our program. Our objective always is to schedule the most informative, most interesting, most educational, and most effective meeting possible.

This year our meeting spans four days, beginning on Thursday and adjourning on the following Sunday. This year we have a general educational meeting scheduled for Friday afternoon and Saturday afternoon with nationally recognized speakers participating in the programs. Specialty Society meetings, for the first time in many years, are all scheduled during the official dates of the Annual Session. We have attempted in every instance to schedule the Specialty Society meetings at the time and place requested. As Chairman of the Committee on Annual Session, I appreciate the cooperation that I have received from the Specialty Society local arrangements chairmen.

The following dates for future meetings have been approved: 1971—Atlanta, Georgia, May 13-16; 1972—Macon, Georgia, May 4-7; 1973—Augusta, Georgia, May 3-6.

We have redesigned the pocket size program, which is mailed to every member of the MAG prior to the Annual Session, to make it more compact.

The House of Delegates of the MAG at the 1969 Annual Meeting approved the recommendation of this committee that the format of our annual meeting as programmed this year be continued for at least five years.

This Committee would appreciate your constructive comments. We do not have any further recommendations at this time.

Blood Banks Committee

LEE HOWARD, JR., M.D., Chairman

No meetings were held during the year. The annual meeting, scheduled for July 26, was cancelled because so few members indicated that they could attend.

No problems were referred to the Committee, and therefore no subsequent meetings were required.

Disaster Medical Care Committee

VIRGIL B. WILLIAMS, M.D., Chairman

The Chairman has been in correspondence with committee members as the need arose.

Liaison with State Civil Defense authorities has been maintained. This particularly concerns their promise of transportation and housing of physicians at major disaster scenes.

Close study has been made of all communications from AMA in reference to disaster medical care.

A representative of the committee attended the MAG Committee Conclave on July 26-27, 1969. Aspects of disaster medical care were discussed at this meeting. The Chairman attended a Greater Atlanta Medical Disaster Committee meeting at the city auditorium in Atlanta in September, 1969.

Hurricane Camille raised questions as to our state of preparedness. Physicians in coastal areas inquired as to locations of disaster supplies. The MAG Journal is publishing an article outlining the procedure for use of preplaced disaster hospital medical supplies. An accompanying map indicates the location of the Civil Defense Emergency Hospitals and Supplies.



Preston D. Ellington, M.D., Vice Speaker, addresses the MAG House of Delegates.

The Committee has been ready at all times to assist county societies in planning Disaster Medical Care programs. Information concerning Disaster Medical Care programs has been distributed to county societies requesting such.

Finance Committee

BRASWELL E. COLLINS, M.D., *Chairman*

Your Finance Committee is pleased to report that the Association has completed another successful financial year. The building project, of course, has created a 19-year obligation requiring monthly payments of \$4,541. Reimbursements of expenses by those programs using the new facilities will tend to offset expenses occurred there.

This year we are changing from calendar year financing to a fiscal year of June 1-May 31, and for the first time, the House of Delegates can be told at the beginning of the year what MAG plans to do with its funds. Even though no action will be required, the budget as adopted by Council will be read to the House of Delegates on the floor, as a supplemental report of this Committee.

The Committee wishes to express its appreciation to the MAG Headquarters Staff for the many services rendered during the year.

Governmental Medical Services Committee

CHARLES B. WATKINS, M.D., *Chairman*

The MAG Committee on Governmental Medical Services met July 26, 1969, at the Marriott Motor Hotel, Atlanta, Georgia. Dr. Charles Todd was elected Vice-Chairman of the Committee.

The Committee heard a review of the status of governmental programs given by several physicians who are involved with governmental programs. The Committee also heard from Mr. James Willis of the Social

Security Administration explaining what is being done regarding some aspects of Medicare.

There was a broad discussion of many problems involving governmental medical services and no definite recommendations were made by the Committee.

This Committee has been provided bulletins and copies of new regulations regarding governmental services.

This Committee stands ready to assist or advise in any way with any problems that may arise in this field.

Historical Committee

MILFORD B. HATCHER, M.D., *Chairman*

The Historical Committee is working on the history of medicine in Georgia and attempting to correlate and itemize the vast source of historical events in regards to medicine in the state of Georgia. This will be a momentous task, and will take years to completely compile.

The untimely death of Professor Horace Cunningham of the Department of History at the University of Georgia has temporarily delayed progress along these lines for the present time. Attempts are being made to secure someone to continue Dr. Cunningham's project.

Contact has been made with the Stone Mountain Authority and the Director of the Stone Mountain Park regarding displays of medical history of the state of Georgia so it can be viewed by visitors.

Medicine and Religion Committee

IRVING L. GREENBERG, M.D., *Chairman*

The Medicine and Religion Committee had an excellent turnout at the Annual President's Conclave held in Atlanta shortly after the new administration took office. The result of the discussions held during the meeting, I believe, motivated programs in various communities which were meaningful in bringing clergy and physicians closer together in the best interest of our patients.

In October, your committee Chairman was invited to share in planning for a convocation on Medicine and Religion to be held October 8-10, 1970 at the Hilton Inn, Atlanta. This will be a regional convocation to be sponsored by the Southern Jurisdictional Council of the United Methodist Church. Carl Bailey of the MAG Staff, along with two or three other MAG members, helped to plan what should be a worthwhile meeting and I would urge any of our members to attend if they can do so.

Your Chairman also attended the one day regional meeting for State Chairmen of Medicine and Religion Committees held on February 28 with Doctor Paul McCleave (AMA) and representatives of some 11 or 12 states. It was clear that a great deal of progress has been made throughout the region and the nation in developing a meaningful program in Medicine and Religion.

Mental Health Committee

A. S. YOCHER, M.D., *Chairman*

This Committee met formally on one occasion to endorse the new Mental Health Code in reference to

the patient's Bill of Rights. Also, a poll of the Committee members endorsed appropriate legislation to better control the use of hypnosis. Aid to the Mental Health Committee of the Medical Association of Georgia's Auxiliary in providing a Speakers Bureau was discussed and encouraged.

Arrangements are being made through the Mental Health Committee to purchase films on Drug Abuse, which are on constant demand by physicians and the public. The Mental Health Committee plans to have a representative attend the Annual Conference of State Mental Health Representatives sponsored by the American Medical Association.

Professional Conduct and Medical Ethics Committee

T. A. SAPPINGTON, M.D., *Chairman*

At the time that this report is written, there has not been a full committee meeting. It is anticipated that a full meeting of the committee will be held before the next meeting of the Medical Association of Georgia as there are some problems that have been referred to the committee, and apparently a satisfactory solution to these problems are impossible without a meeting of the entire committee.

A fairly large number of complaints have been received during the past year, but most of these have been handled at the local society level after being referred to the local societies.

Your chairman has made several trips to MAG Headquarters concerning this committee's activities. Follow-up information has been obtained on all cases. A file is kept at headquarters on each complaint received. There have been many telephone conversations concerning complaints received by your chairman and he has met at length with one of the individuals who has brought a complaint before this committee.

Without the very able and conscientious help of Edwin Smith, your committee could not possibly have functioned as well as it has. My sincere appreciation is expressed to Mr. Smith for his assistance, the many letters he has written for me and the many telephone calls he has made to keep me always currently informed as to any complaint received and for the accurate and complete file he has kept on each problem that has been brought to this committee.

Rural Health Committee

THOMAS N. LUMSDEN, M.D., *Chairman*

The Rural Health Committee of the Medical Association of Georgia has had a fairly busy year. It has met on a number of occasions, one of which was at the time of the Committee Conclave in July. In addition to meetings of its members it has met on two occasions with its Advisory Council to consider subjects of mutual concern.

One of the major activities of this year as well as of previous years has been that of co-sponsoring, with the Georgia Farm Bureau, the Rural Health Conference which this year for the first time was held in Macon. This was thought to be an improvement and the next conference scheduled for this fall will be held there also. The 1969 program included a Keynote Ad-

dress by Dale Clark, Public Affairs Director of WAGA T.V.; Dr. Fleming Jolley, who spoke on "Emergency Highway Care"; Charles Skinner, Director of Georgia Motor Trucking Association, who discussed "Traffic Safety in the Trucking Industry." "The Role of the Medical College of Georgia in Training Family Physicians" was presented by Dr. Glen Garrison; "Changing Requirements in Immunization," by Dr. John McCroan; "Cardiopulmonary Resuscitation," by Dr. Joseph Wilbur; "Dog Control Regulations," by Dr. John McCroan; "Environmental Pollution, Cause and Cure," by Mr. William Hansell, and "Water," "Solid Waste" and "Conservancy" concluded the discussions. The program for this fall's conference has been planned and speakers engaged.

Members of the Rural Health Committee have met with representatives from the Georgia Regional Medical Program to lay plans for initiating a preceptor program for the state of Georgia. It is anticipated that this will be carried out through cooperation with the two medical schools in the state and with the Georgia Academy of General Practice. Several joint conferences with each of the participating groups have been held.

The Rural Health Committee, the Georgia Farm Bureau and the Georgia Academy of General Practice are cooperating to promote interest in the development of the Division of Community Medicine at the Medical College of Georgia. This division at present is not an active one. It is felt that a strong program here would interest physicians in rural practice.

The Medical Association of Georgia was represented at the National Rural Health Conference held in Philadelphia in March, 1969. MAG's activities in the field of Rural Health were recognized by the American Medical Association when the Chairman of Georgia's Rural Health Committee was invited to serve on AMA's Council on Rural Health.

Separate Billing Committee

DONALD R. ROONEY, M.D., *Chairman*

During the past year this committee has functioned to help preserve the concept of the private practice of medicine. Members of this committee helped with series of lectures to residents at Talmadge Hospital in Augusta and Grady Hospital in Atlanta on the importance of independent practice with separate billing, as opposed to percentage employment contracts with hospitals.

Information was supplied to several hospital-based physicians on the mechanism of independent practice with separate billing.

Meetings were held with Medicare officials to solve problems associated with separate billing by hospital-based specialists.

The major accomplishment of this committee was the compilation of "Guidelines for Staffing Hospital Emergency Departments." All committee members participated in writing these guidelines. They were reviewed by the MAG legal counsel and subsequently approved by the Council of MAG. Copies were mailed to county medical society officers and hospital medical staff officers. It is hoped that these officers will see to it that these guidelines are followed in their local hospital emergency departments.

Emergency Room coverage by physicians on a full time basis is expanding and it is hoped that these guidelines will help avoid the many problems which arise when physicians allow the hospital to bill and collect for them by means of a percentage contract.

Speaker Rogers then called attention to four Special Reports not referred, submitted by the Editor of the *Journal-MAG*, Dr. Edgar Woody; the President of the Woman's Auxiliary, Mrs. S. William Clark; the Coordinator of the Georgia Regional Medical Program, George H. Alexander, M.D.; and the Director of the Georgia Regional Medical Program, J. Gordon Barrow, M.D.

The Journal

EDGAR WOODY, JR., M.D., *Editor*

The 1969-1970 report of the *Journal of the Medical Association of Georgia* is submitted herewith:

PERSONNEL

Since our last annual report, Miss Kay Rucker has submitted her resignation as Managing Editor to accept another position. During her tenure of one year she made many good contributions to the *Journal* and her resignation was accepted with regret.

We were fortunate to secure Miss Pat Thigpen as our new Managing Editor. Miss Thigpen is a graduate in Journalism from Georgia State College and came to us with high recommendations. Her enthusiasm for journalism is reflected in the superior quality of her work.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

This non-profit bureau in Chicago which solicits and sells advertising for the State Journals continues to do a good job for us. Even though some moderate cutbacks in advertising volume have taken place during the past year, the Bureau has maintained an aggressive sales force in frequent contact with the national pharmaceutical firms. A readership survey of state journal readers is being planned and the results will be utilized in sales promotion.

The seminar sponsored by the Bureau last fall in Chicago was well attended and was highly instructive. It was especially useful for Miss Thigpen since it brought her into contact with journal personnel from other states.

CONTENT

The *Journal* has been fortunate to have received an increasing number of papers for consideration for publication. A series of clinical conferences from the Medical College of Georgia have been particularly instructive and interesting. More of these clinical conference transcripts are being edited and will appear in the *Journal* at an early date. More special articles have been featured in the *Journal* during the past year and have stimulated favorable comment.

CREDITS

The Publications Committee has continued to be a strong guiding hand in the affairs of the *Journal* and

its wise counsel is much appreciated. Our Contributing Editors have remained active representatives of the *Journal* in geographic and specialty areas. Especially noteworthy has been the high quality and refreshing style of the President's Page. Our President is not only an outstanding physician but an accomplished writer. Our specialty pages produced by authorities in their respective fields have continued to lend luster to the quality of the *Journal*. The Headquarters Office staff with their numerous contributions and suggestions continue to play a key role in the publication of the *Journal*. Their efforts are much appreciated.

The Woman's Auxiliary to the Medical Association of Georgia

Mrs. S. WILLIAM CLARK, JR., *President*

The theme for the Woman's Auxiliary in Georgia this year has been "Project Auxiliary Concern." Emphases were placed on worthwhile health-related activities and on having a concerned, effective membership.

Since the purpose of an auxiliary is to help medical societies as needed, each auxiliary has considered the needs of its own society and community, then proceeded in appropriate directions.

One concern has been in working toward better public relations. We feel doctors' wives can help in this area through meaningful projects actually related to health. These show the concern of their own husbands and of medicine . . . a concern which the doctor often is unable or unwilling to show himself. Hoping to better educate the public on good health practices, we have provided many programs and study courses with films and speakers for PTA, youth and other civic groups. This is a major service of auxiliaries.

We have assisted, either as individuals or auxiliaries, in a multitude of health clinics and drives and in widespread projects for personal, traffic and home safety.

Desiring to be well-informed ourselves so our conversation with the public would be factually correct and helpful to medicine, we have had stimulating programs for ourselves and occasionally have included wives of dentists, druggists and the general public in our meetings. Most auxiliaries have regular capsule reports on legislation related to medicine and stress participation and interest in local politics.

A prime concern this year has been in the field of Health Careers. We have tried to reach guidance counselors and youth, beginning now to contact those in junior high schools, also, with Health Careers programs, field trips, fairs, etc. Recently the auxiliary purchased an appealing four-part film strip series on Health Careers which will be on loan from the MAG office. Effective exhibits have been placed in shopping malls and other prominent locations.

Many auxiliaries have worked to provide paramedical scholarships and also contribute to Georgia's own William R. Dancy, M.D. Student Loan Fund. Our contributions to AMA-ERF which help our Georgia medical schools and loan guarantee totaled, in March, \$6,212.91. Perhaps you helped us raise money for this by buying our golf balls, rose bushes, countless other items, or by attending benefit parties.

Other concern has been shown through assistance in clinics for mental health, on drug abuse, in Friendship Houses for the lonely, in schools for the mentally retarded and in significant quantities of gifts, remembrance cards and craft supplies sent to various state mental institutions.

Activities for helping international health included purchase of equipment for needy hospitals, sending linens, bandages, drugs, eyeglass supplies, no-longer-used medical instruments and medical literature as requested.

Our national theme, "Accent on Youth," and a new committee on Children and Youth have focused attention on the importance of a strong family unit and on studying the needs of youth in our own communities. Your wives were urged to write opinion letters to important, policy-making individuals in order to exert pressure for good.

Another new committee, Home-Centered Health Care, encourages home nursing and health aid services.

One area of auxiliary concern is in preserving records of medicine in Georgia. Each year most groups write articles on some phase of medical history in their area; we hope this is being done in the sections where doctors and their wives do not have an auxiliary program.

A very important purpose and concern of the auxiliary is in seeking to provide a warmth of friendship and fellowship so helpful in the medical community. Through our state meetings and publications we exchange ideas for a variety of socials, programs and activities. A School of Instruction during the May Convention and two workshops during the year were provided to stimulate and inform our state and county leaders.

Concern has been shown in increasing our membership, which in turn should help to make much more effective our auxiliary help to medicine. Our latest figures are: 3,625 members of MAG; 2,216 auxiliary members; 67 medical societies; 38 auxiliaries; 400 doctors where no auxiliary exists, 53 auxiliary members-at-large.

These show an increase of over 400 this year due to having two new auxiliaries and to a new practice of some groups of billing the husband's office for the wife's dues, which makes it a deductible item. However, we do not consider these statistics good and wish every doctor would want his wife to be an auxiliary member and would encourage her to participate actively.

The auxiliary is extremely grateful for your financial support and for the Auxiliary Room in the MAG Headquarters Building with its handsome cabinets, in addition to the many other ways you have contributed to our program. I personally have appreciated the courtesies and friendships made with you and your lovely wives throughout the state and also their energetic activities which enable me to bring you this report of worthwhile auxiliary participation.

Some groups are not very active because their medical societies do not ask them for assistance or perhaps show little appreciation for their auxiliary efforts. We do hope as you see a need you will call on them.

Auxiliary members realize that doctors' wives have

a part in the total picture of medicine. We know we receive many benefits from this profession, of security and of a high social position. Most wives have sufficient talent and ability to exert a wide influence for good for you and medicine and for our entire country. This year they have been encouraged to use these to fullest advantage.

The essence of my report is that your auxiliary is anxious to help you, and many of your wives have worked diligently this year to do so as they have endeavored to "Project Auxiliary Concern!"

Georgia Regional Medical Program

GEORGE H. ALEXANDER, M.D., *Coordinator*

Effective October 15, 1969, I became Georgia Regional Medical Program Coordinator following the resignation of J. W. Chambers, M.D., for reasons of health. I attended the December Council Meeting making a brief report, but I felt that I was hardly "dry behind the ears." Since then, I have attended the Steering Committee Meetings and several meetings of the Core Staff, the Regional Advisory group meetings, and have had several conferences with Doctor Barrow, Mr. Adams, the Georgia Regional Medical Program fiscal officer, and also Miss Franklin and Mr. Smith of the MAG staff. Additional Executive Committee meetings and the March Council Meeting have also been attended. As a result of the foregoing and many hours spent in reading and in examining monthly financial reports, I am beginning to feel that I am about to get "my feet on the ground." However, it will be some time yet before I can approach the effectiveness of Doctor Chambers, if ever.

As of late March we were in the position of having several (10) approved but unfunded projects due to approximately 20 million dollars of Regional Medical Program funds being held up for carry over by the Bureau of the Budget. Since that time, additional projects have been approved and are awaiting necessary funding for implementation. The Georgia Regional Medical Program's share of the 20 million held up amounts to about \$790,000. Word has recently been received indicating that the Bureau of the Budget has agreed to release the 20 million in carry over funds—five million in fiscal 1970, and the remaining 15 million in fiscal 1971. This will provide 78.5 million for fiscal 1970, and 94.5 million during fiscal 1971. Georgia Regional Medical Program should be in good position with its share of these funds to implement its backlog of unfunded projects as well as additional newly proposed projects.

At the present, we have 24 projects which are actively operable. With the additional funds to be available for funding of other already approved projects and others to probably be approved, it is felt that we in Georgia have an overall program in which we can and should take pride. At present we are receiving approximately 2.5 million annually for the funding of our program. Our Director is Chairman of the National Coordinators and is doing a job in which we all can take pride. He is being asked by me to make a separate report covering the scope of the operational projects.

We of the Georgia Regional Medical Program are happy and proud to be in our new quarters in the new

addition to the MAG Headquarters building. It is gratifying to have such a beautiful and comfortable place in which to work. It is hoped that when you have an opportunity that you will come by for a tour.

It is urged that you and all members of the Association remain alert, and if and when it may be necessary to call upon you that you will stand ready and willing to lend your assistance in not only obtaining adequate funding, but in keeping this program where it should be—under the wing of the private practicing physicians of Georgia.

Operational Projects of Georgia Regional Medical Program

GORDON BARROW, M.D., *Director*

CLINICAL TRAINING CONFERENCES FOR PRACTICING PHYSICIANS

This project offers postgraduate courses of 12 weeks' duration (one day per week) in the categorical diseases. Individually designed courses are available at Emory University and the Medical College of Georgia. Up to the present time, nine different courses have been offered to 34 trainees, 60 per cent of whom come from rural areas. This represents 337 training days.

For 1970, thus far 18 new applications have been received and 15 physicians have reapplied for additional courses.

POST-RESIDENCY TRAINEESHIPS IN PEDIATRIC CARDIOLOGY AND IN HYPERTENSION-RENAL DISEASES

Courses of study of one year's duration are designed for those physicians who are not planning academic or research careers. The traineeships are awarded only to physicians residing within the region who plan to return to their area.

Plans are being completed for two physicians to participate.

VISITING CONSULTANTS PROGRAM TO COMMUNITY HOSPITALS

This project provides consultants to community hospitals either from private practice or medical school faculty. The program is flexible and may be designed for a single specific purpose or for a continuing program of education.

During 1968, four consultants were provided; in 1969 52 were utilized, and at the present time 18 have been scheduled thus far for 1970.

INTERLIBRARY COPYING SERVICE

Free photocopying of medical journal articles and free loan of books is provided to community hospitals, their physicians, and personnel by the two medical school libraries. A union list of serials is also available.

To date, 28 hospitals have participated with over 700 requests. RMP funds have paid for 4,655 pages of copy.

COLUMBUS MEDICAL CENTER-EMORY UNIVERSITY TEACHING AFFILIATION

In an attempt to improve the quality of medical service and to attract additional physicians to Columbus,

this project provides a teaching affiliation between Emory University and the Medical Center in Columbus. The Medical Center, upon Emory's recommendation, is providing funds to add to its staff a full-time director of medical education and full-time chiefs of medicine, surgery, gynecology-obstetrics, and pediatrics. To insure the quality of the teaching program, these positions will carry Emory faculty appointments. Three of the positions have been filled and candidates are being interviewed for the other two.

COMMUNICATIONS NETWORK FOR THE REGION

The communications network provides continuing education for physicians, nurses and allied health personnel through broadcast via state educational television to 41 hospitals in Georgia. The programs are recorded on video tape at each of the receiving hospitals so they may be played back at convenient times for appropriate audiences.

Attempts are continuing to involve physicians and other health care personnel in planning programs which will fill their specific needs.

IMPROVEMENT AND COORDINATION OF FACILITIES FOR CARDIOVASCULAR DIAGNOSTIC SERVICES

Quality facilities for cardiac catheterization, angiocardiology, and coronary angiography will enable five medical centers to provide these services to other hospitals in the Region. A major portion of support is for equipping cardiovascular laboratories at the centers. Before Regional Medical Program support, the laboratories could perform 65 catheterization procedures per week. With Regional Medical Program support, 190 procedures per week are projected.

CARDIOPULMONARY RESUSCITATION PROGRAM

This project is determining the need and resources for CPR in Georgia and is developing a cadre of instructors within an organizational structure that will permit them to carry on training activities in their respective communities. Financial support is also provided by the Georgia Heart Association and the State Department of Public Health.

As of March 5, the total number of instructors trained has been 372; 104 of these have been physicians, 183 have been nurses and 131 have been classified "others." Over 3,500 people have been trained in CPR in 43 counties in the State.

CORONARY INTENSIVE CARE DEVELOPMENT IN SMALL HOSPITALS (CCFS)

In order to provide appropriate consultation for small hospitals, monitored ECG's are transmitted by special telephone line to the nearest medical center having a coronary care unit with trained staff. This project has enabled 140 patients with myocardial infarctions to be monitored by the four participating hospitals.

CONTINUATION OF THE EXPANSION OF THE CCFS

This project, an extension of the original, was based upon the need to collect more data before con-

clusions and recommendations could be made to other hospitals considering this type of patient services. Four additional hospitals are included in the expansion study.

STATEWIDE CANCER PROGRAM

Through a system of 12 Area Cancer Facilities in seven localities, programs of consultation, workshops, and continuing education are available for medical professionals. Over 1,200 patients have been seen in tumor conferences and the cancer workshops have had 250 participants.

A state registry composed of 19 hospital registries is service-oriented for feedback on diagnosis, efficiency of treatment and follow-up. The registry is an encouragement for self-audit and stimulates interchange of professional opinion. It provides evaluation of the cancer activities and epidemiological data. Over 6,600 patients have been listed in the registry.

PEDIATRIC CHRONIC PULMONARY DISEASE CENTER

The respiratory program of the Department of Pediatrics of the Medical College of Georgia is now operational. It was expanded to provide comprehensive care, teaching and research for chronic and potentially disabling respiratory diseases of children. Over 275 patients have been seen by the center.

Support for the program is also received from the National Cystic Fibrosis Research Foundation, The National Foundation and the Augusta Area Tuberculosis and Respiratory Disease Association.

TRAINING PROGRAM FOR MEDICAL SPECIALTY ASSISTANTS

Trainees are given a two-year intensive course in electrocardiography, pharmacology, physiology, and electronic monitoring along with basic nursing care. The purpose is to provide assistants to work under the supervision of physicians in coronary care units. Currently enrolled are 12 trainees; there have been three graduates.

COMMUNICATION AND PUBLIC INFORMATION PROGRAM

As a function of the core administrative staff, the attention of interested groups and the public-at-large is being drawn through various communications media—a newsletter, radio programs, an audiovisual program for the use of public speakers, and a system of press releases.

Core staff activities under this project have included 25 speeches to regional organizations and interest groups, participation in 34 workshops and conferences, as well as contacts in 428 other informal visits and meetings.

DEVELOPMENT OF AREA PROGRAM

Primarily for administrative and staffing purposes, the state of Georgia has been divided into five areas. Area offices have been established in four geographical locations—Macon, Albany, Atlanta, and Savannah. The Atlanta office is serving two areas. The area offices are staffed by a program representative and full-time secretary in order to give ready access of the Program to the health care institutions and agencies

in each area. In addition to liaison between GRMP and local hospitals, the program representative maintains contact with project directors and local advisory groups in his area.

A physician director provides medical expertise for the program representatives. He and the program representatives represent GRMP at hospital medical staff meetings and in other medically related consultative areas.

DEVELOPMENT OF AREA FACILITIES FOR CONTINUING EDUCATION

The primary responsibility of each facility will be to plan, promote, coordinate, and evaluate ongoing programs of continuing education for physicians, nurses, and other allied health personnel both in the area facility and in smaller surrounding hospitals. Ultimately, 15 Area Facilities are projected.

Five Area Facilities have been funded to provide a part-time physician continuing education coordinator and a full-time allied health continuing education coordinator.

DEVELOPMENT OF A SYSTEM OF CORONARY TRAINING FOR THE REGION

There are 3 components to this project:

(a) Through Georgia Baptist Hospital in Atlanta there is a four-week training program for RN's.

(b) Through Archbold Memorial Hospital in Thomasville there is offered concurrently a two-week program (1 day weekly/10 weeks) for RN's and a program to train physicians in coronary care unit management.

(c) Through GRMP there is a full-time coordinator to provide consultation and supervision for the nurse training programs and to coordinate use of the ROCOM system.

SHORT-TERM TRAINING TO IMPROVE TEACHING COMPETENCIES IN CARDIOVASCULAR PHYSIOLOGY FOR MEDICAL-SURGICAL NURSING INSTRUCTORS

This is an inter-regional project for short-term training programs in cardiovascular physiology for nursing instructors in the Southeast. Its purpose is to improve care of patients by strengthening instruction in basic nursing programs. These courses, the first of their kind in the U.S., will be offered at Georgia State University in the form of two three-week courses each summer.

A RENAL FAILURE TRAINING AND DEMONSTRATION PROGRAM

This program, submitted by the Medical College of Georgia, is aimed at training three levels of nurses—instructor, supervisory, and bedside nurses. In addition, a multidisciplinary team including a physician nurse and technologist will supervise patients in home dialysis. These trained personnel will probably be located at the area facilities for stroke.

A TEACHING, TRAINING, AND DEMONSTRATION PROGRAM IN HYPERTENSION AND NEPHROLOGY

The goal of this project, located at Emory University School of Medicine, is to produce a multidisciplinary

nary team for work in conjunction with a nephrologist in combination office-hospital practice in smaller communities. This is to be achieved by instituting training programs for practicing physicians; RN in renal nursing; renal technologists and technicians, social workers and dietitians.

PHYSICAL THERAPY FEASIBILITY STUDY

This project was designed to develop a mechanism for cooperative multi-county utilization of physical therapy services. The primary objective is to extend these services into rural areas which have not had such services available. To date nine counties, a district health department and several nursing homes are participating.

A COOPERATIVE EDUCATIONAL AND SERVICE PROGRAM IN THE AREA OF CHRONIC PULMONARY DISEASES IN NORTHEAST GEORGIA

An 18-week training course for inhalation therapy aides is conducted each year for two years. The program is centered at Athens General Hospital under the supervision of Doctor Goodloe Erwin. Currently, 14 trainees from seven hospitals are enrolled.

AMA Delegates

J. W. CHAMBERS, M.D., *LaGrange*

Since my last report to the House of Delegates of the Medical Association of Georgia, many of you know I have had the misfortune of missing the Annual Session of the American Medical Association in New York City in July of 1969. From the reports that I have had from the various members of our delegation this was a most active meeting of the AMA House of Delegates and, of course, the highlight of the meeting was the Georgia Delegation being successful in the election of J. Frank Walker as the Vice Speaker of the American Medical Association House of Delegates. The entire membership of our delegation should be commended for this achievement and I would like to add my own congratulations for their efforts as well as publicly to J. Frank Walker, M.D. Of course, all of us in Georgia know that there is no better speaker of the House of Delegates and we hope that before many years Dr. Walker will have a chance of becoming Speaker of the House of Delegates of the American Medical Association. I would not in any way be able to say that the function of the Georgia Delegation was impaired by the absence of your chairman since the House of Delegates of the AMA considered some 131 resolutions during the course of the session. They received and acted upon 36 reports submitted by the Board of Trustees of the AMA as well as reports from the Judicial Council, from the Council on Constitution and Bylaws, eight reports from the Council on Medical Education, eight reports from the Council on Medical Service as well as several other reports from various committees of the House and the Board. All of these were acted upon in a judicious manner and reports of all the actions of the House are available from my files and from the files of the Medical Association of Georgia for anyone's information who

would care to read them. Various members of our delegation will appear before the Reference Committees to make any information available to the members of the Reference Committee and subsequently to this House.

Your chairman had the good fortune to attend the clinical session of the House of Delegates held in Denver, Colorado, in December, 1969. This also was a busy session for all of us with the usual number of reports and resolutions. These were acted upon with one exception in a fairly judicious and rapid manner. The one exception to this was the report submitted by the Planning and the report of the committee on Planning and Development, or more commonly referred to as the Himler report. This report created sufficient interest so that it was referred to a special reference committee and the report of this committee is available for all who would be interested to read since it is a quite voluminous report and many of the suggestions and the result of a very exhaustive and carefully studied critique from our own delegation and our own Council of MAG will be given to this House for information during this session.

Your delegation continues to be active in the representation of the Medical Association of Georgia before the American Medical Association House of Delegates. Many of the members of your delegation are chosen as you have been told before to serve on various reference committees and other committees of the House of Delegates of the AMA. This, I believe, helps to bear out the effectiveness of our delegation. Various members of the delegation will be in attendance at this House of Delegates meeting from time to time and we shall be happy to consult with any member or members of the House who should like to have specific information about specific issues.

May I again assure you that it has been a pleasure for all of us to serve you this past year.

President Train then expressed appreciation for the excellent reports submitted by those officers and Chairmen who worked during his year in office and then introduced the following motion:

Motion: That this First Session of the House of Delegates adopt with commendation all reports not specifically referred to Reference Committees for further consideration.

This motion was duly seconded and passed and Speaker Rogers announced that all reports indicated as "Not Referred" were adopted with commendation.

Speaker Rogers then called special attention to the excellent address delivered by the Incoming President, F. G. Eldridge, at the First General Session, Thursday, May 7, 1970, referred to Reference Committee B.

Speaker Rogers proceeded with unfinished business, calling for the submission of Supplemental Reports from Officers, Councilors, or Committee Chairmen.

Supplemental Report 70-1: Committee on Constitution and Bylaws—Reference Committee C

Supplemental Report 70-2: Committee on Constitution and Bylaws—Reference Committee C

Supplemental Report 70-3: Council—Reference Committee B

Speaker Rogers stated that at this time the House of Delegates would consider New Business which concerned the introduction of Resolutions. The following Resolutions were then presented:

Resolution 70-1: Peer Review—Reference Committee D

Resolution 70-2: Election Procedure of the GP of the Year—Reference Committee A

Resolution 70-3: Medical System for Mass Casualty Situations—Reference Committee E

Resolution 70-4: Abortion Laws—Reference Committee A

Resolution 70-5: Voluntary Proficiency Testing of Physician Office Laboratories—Reference Committee C

Resolution 70-6: Availability and Abuse of Amphetamines and Other So-Called Appetite Suppressants—Reference Committee E

Resolution 70-7: Commendation to Kiwanis Clubs of Georgia—Reference Committee E

Resolution 70-8: Commendation to Georgia Junior Chamber of Commerce—Reference Committee E

Resolution 70-9: Commendation to Lions Clubs of Georgia—Reference Committee E

Resolution 70-10: Repeal of State Laws on Serological Test for Syphilis as a Prerequisite for Marriage Licenses—Reference Committee C

Resolution 70-11: MAG Establish a Committee on Private Practice—Reference Committee D

Resolution 70-12: Endorsement of Traffic Safety Legislation—Reference Committee E

Resolution 70-13: Chiropractic—Reference Committee C

Resolution 70-14: Let the Bedside Physician Be the Guideline—Reference Committee D

Resolution 70-15: GaMPAC Commendation—Reference Committee C

Resolution 70-16: Medicaid Payment for Sterilization—Reference Committee A

Resolution 70-17: Workmen's Compensation—Reference Committee D

Resolution 70-18: Fraud Disclaimer on Medicaid Claim Forms—Reference Committee D

Resolution 70-19: Support of Hospital Utilization and Review—Reference Committee D

Resolution 70-20: Committee to Study Malpractice Suit Problems—Reference Committee B

Speaker Rogers then called for additional resolutions and there were no additional resolutions received at the First Session of the MAG House of Delegates.

Speaker Rogers then recognized President-Elect F. G. Eldridge, who announced that since committees had been appointed by the Executive Committee at its April meeting, it would be his privilege to introduce to the House of Delegates the Committee Chairmen who would serve with him during 1970-

71. Dr. Eldridge called on the Delegates to take back to their County Medical Societies the message that MAG is a Committee Organization and that those Chairmen he was about to introduce had accepted responsibilities which included assisting the County Societies with projects and problems. Dr. Eldridge then read the list of MAG Committees and Committee Chairmen and asked those present to stand and be recognized. He then explained the primary purpose of each Committee as follows:

COMMITTEE ON ANNUAL SESSION

Preston D. Ellington

This Committee, of course, has the singular purpose of planning our Annual meetings. That's easy to say, but we all know the tremendous job that statement represents.

COMMITTEE ON CONSTITUTION AND BYLAWS

George H. Alexander

This Committee reviews our Bylaws completely every five years, and annually prepares any amendments directed by this House of Delegates or the Council.

COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

T. A. Sappington

This Committee serves as our mediation and Complaints Committee—a sticky job, but with excellent leadership.

COMMITTEE ON EMERGENCY MEDICAL SERVICES

Robert E. Wells

This Committee is concerned with traffic safety and related emergency care and safety matters.

COMMITTEE ON WOMAN'S AUXILIARY

S. William Clark

This is the Committee everyone wants to serve on, but Billy manages all its "affairs." Seriously, this is an advisory board which counsels the Auxiliary in any way requested.

Special Committees

ALLIED HEALTH CAREERS

John T. Godwin

This Committee's primary duty is encouraging students to seek a career in medical or allied health fields.

AREAWIDE HEALTH PLANNING

F. William Dowda

This Committee is charged with the responsibility of encouraging the participation of physicians in the formation of planning councils in their areas.

BLOOD BANKS

Lee Howard, Jr.

All matters regarding blood bank operation including plasmapheresis centers are referred to this Committee.

CANCER

Hoke Wammock

This Committee attempts to coordinate the many cancer programs in Georgia.

CRIPPLED CHILDREN

H. R. Foster

This Committee is concerned with the Crippled Children's Service in Georgia.

DISASTER MEDICAL CARE

Virgil B. Williams

This Committee collects and distributes information on Georgia's Disaster Medical Care Plans.

ECOLOGICAL

John Kirk Train, Jr.

This new Committee will deal with all facets of environmental pollution.

GOVERNMENTAL MEDICAL SERVICES

Charles B. Watkins

This Committee receives reports on all the Government third party programs and serves as liaison with them.

HISTORICAL

Milford B. Hatcher

The development of a history of medicine in Georgia will consume this Committee's entire time.

HOSPITAL ACTIVITIES

James M. Skinner

This Committee's name discloses its area of responsibility with subcommittees handling hospital-physician disputes, and liaison with the Georgia Nursing Home Association.

INSURANCE AND ECONOMICS

William W. Moore

This Committee maintains surveillance over all our group insurance plans.

LEGISLATION

J. Frank Walker (National)

Harrison L. Rogers (State)

This Committee handles all legislative matters with both the Congress and the State General Assembly.

MATERNAL AND INFANT WELFARE

Eugene L. Griffin

This Committee studies all maternal and fetal deaths in the State.

MEDICAL EDUCATION

Luther G. Fortson

This Committee guides all matters of continuing education including student liaison and sponsors a biennial conference.

MEDICAL REVIEW AND NEGOTIATING

John R. McCain

This is currently our most active Committee and this House has before it this year a recommendation that its scope of authority be expanded to include all facets of peer review.

MEDICINE AND RELIGION

M. D. Pittard

Liaison with the clergy to develop methods of treatment of the whole man is this Committee's duty.

MENTAL HEALTH

A. S. Yochem

This Committee is concerned with Georgia's mental health program including drug dependence and abuse.

NURSING LIAISON

Charles Eberhart

Liaison with the nursing profession with a special interest in nurse education is this Committee's responsibility.

OCCUPATIONAL HEALTH

Tom S. Howell, Jr.

This Committee is concerned with industrial medicine and Workman's Compensation matters.

PHYSICIAN-LAWYER LIAISON

J. Frank Walker

Surveillance of relationship guidelines is the continuing responsibility of this Committee along with a corresponding group from the Georgia Bar.

PUBLIC RELATIONS

J. Watts Lipscomb

The County Society Officers Conference and news media relations are the responsibility of this Committee.

RURAL HEALTH

Irving D. Hellenga

This Committee concerns itself with health care delivery and opportunities in rural areas of our State, plus liaison with 4-H, Grange, Farm Bureau and other rural oriented organizations. This active Committee has been active in developing a rural preceptorship program, and next year will assist the AMA in conducting the National Rural Health Conference in Atlanta, March 26-27.

SCHOOL CHILD HEALTH

Fred L. Allman

The Annual Conference on Medical Aspects of Sports and plans for Statewide pre-school vision and

hearing testing are this Committee's main responsibilities.

SEPARATE BILLING

Donald R. Rooney

Hospital based physician contracts and emergency room staffing are continuing concerns of this Committee.

TALMADGE HOSPITAL LIAISON

Paul T. Scoggins

This Committee stands ready to assist that dynamic institution with any problems.

Dr. Eldridge then stated that other committees would be appointed during the year as needed and reminded the Delegates that the Chairman of the

Committee on Finance would be selected by the Chairman of Council at its organizational meeting on Sunday, May 10. Dr. Eldridge then asked that the present Committee on Awards continue and also asked that Chairman, John S. Atwater, continue to serve in that capacity.

Speaker Rogers then thanked the Delegates serving on the Credentials Committee, the Tellers Committee and the five Reference Committees and on noting that the business of the First Session of the House of Delegates had been completed, he adjourned the First Session of the MAG House of Delegates on motion duly made and seconded at 11:30 a.m.

MAG General Assembly

116th Annual Session of the Medical Association of Georgia

Friday, May 8, 1970

THE GENERAL ASSEMBLY of the 116th Annual Session of the Medical Association of Georgia was called to order by President John Kirk Train, Jr., Savannah, at 11:30 a.m., in Room B of the Aquarama, Jekyll Island, Georgia, on May 8, 1970.

President Train announced an interesting program, and that an outstanding nationally-known speaker had been selected to deliver the Calhoun Lecture. President Train explained that the A. W. Calhoun Lectureship was established 40 years ago for the purpose of bringing outstanding men to Georgia for our benefit. He further expressed the appre-

ciation of the Medical Association of Georgia to the family of Dr. F. Phinzy Calhoun for establishing this Lectureship in honor of his father.

President Train then introduced Carroll L. Witten, M.D., of Louisville, Ky., an Instructor in Medicine, University of Louisville School of Medicine, with many outstanding achievements to qualify him as the Calhoun Lecturer.

Following the lecture, President Train thanked Dr. Witten for his thought-provoking message and declared the General Assembly adjourned at 12:30 p.m.

MAG Annual Banquet

116th Annual Session of the Medical Association of Georgia

Saturday, May 9, 1970

THE ANNUAL BANQUET of the 116th Annual Session of the Medical Association of Georgia was held in the Rotunda, Aquarama, Jekyll Island, following a reception sponsored by the Glynn County Medical

Society. President John Kirk Train, Jr., M.D., Savannah, presided and served as Master of Ceremonies for the evening.

Following dinner, President Train introduced

those sitting at the head table as follows:

President John Kirk Train, Jr. and Mrs. Train; President-Elect F. G. Eldridge and Mrs. Eldridge; Secretary John Rhodes Haverty and Mrs. Haverty; Chairman of Council C. E. Bohler and Mrs. Bohler; Auxiliary President Mrs. S. William Clark and Dr. Clark; Auxiliary President-Elect Mrs. Charles R. Smith and son, Michael; Glynn County Medical Society Auxiliary President Mrs. John L. Hobson and Dr. Hobson; Glynn County Medical Society Auxiliary Local Arrangements Chairman Mrs. W. Jack Smith and Dr. Smith; Glynn County Medical Society Auxiliary Local Arrangements Co-Chairman Mrs. Willard A. Snyder and Dr. Snyder; and AMA Department of Medicine and Religion Director Rev. Dr. Paul B. McCleave.

President Train then introduced Past Presidents of the Medical Association of Georgia who were seated at a special reserved table and also introduced the following program participants who were also seated at a special reserved table:

Dr. Carroll L. Witten, of Louisville, Ky., the 1970 Calhoun Lecturer; Dr. Paul Knappenberger, of the Fernbank Science Center, Atlanta; Dr. James Harkness, of the University of Kentucky; and Mr. Marvin Rowlands, Chicago, Editor of the *American Medical News*.

President Train then announced that as evidence of the Association's and organized medicine's vital and continuing interest in Georgia's two outstanding Medical Schools, he would present unrestricted grant monies raised by contributions from physicians and Woman's Auxiliaries during the year 1969 to representatives of Georgia's two Medical Schools.

In recognition of the vital role played by the Woman's Auxiliary to the MAG in obtaining contributions to the American Medical Association's Education and Research Foundation, President Train called on Mrs. S. William Clark, President of the Woman's Auxiliary to present checks in the amount of \$4,627.96 to Dr. Chris Fordham, Dean of the Medical College of Georgia, for that institution, and in the amount of \$5,879.86, to Dr. Harry L. Williams, Associate Dean, Division of Allied Health Sciences, Emory University School of Medicine, for the Emory University School of Medicine.

Certificates of Appreciation

President Train then stated that the Medical Association of Georgia wished to present a Certificate of Appreciation to an individual who would be unable to be present for the awards ceremony the following day. President Train then presented the Certificate of Appreciation to the President of the



Contestants for the Medical Mile line up on Jekyll's hard-packed sandy beach.

Woman's Auxiliary to the Medical Association of Georgia, Mrs. S. William Clark, of Waycross.

President Train then recognized Dr. F. William Dowda, who presented an MAG Certificate of Appreciation to Dr. Ronald F. Galloway, of Augusta, Outgoing First Vice President of the Medical Association of Georgia.

President Train next recognized Dr. Harrison L. Rogers, who presented an MAG Certificate of Appreciation to Dr. Preston D. Ellington, of Augusta, Chairman of the Committee on Annual Sessions.

Scientific Exhibits Awards

Dr. John N. McClure, Atlanta, Chairman of the Association's Committee on Scientific Exhibits, was then called on by President Train to announce the winners in the 1970 Scientific Exhibit as follows:

First Place—"Genital Herpetic Infection and Cervical Cancer"

Zuher M. Naib, M.D.; Andre J. Nahmias, M.D.; and William E. Josey, M.D., *Atlanta*

Second Place—"Airborne Pollens and Fungi"

Betty B. Wray, M.D.; Marianne Holsenback, and Gayle Scott, M.T. (ASCP), *Augusta*

Third Place—"The Treatment of Fracture—Dislocations of the Lumbodorsal Spine"

Thomas E. Whitesides, Jr., M.D.; Robert P. Kelly, Jr., M.D.; and W. Slocum Howland, Jr., M.D., *Atlanta*

Golf Prizes

President Train then announced that Dr. J. L. Hunt, Chairman of the 1970 MAG Annual Session Golf Tournament, was unable to be present but that the winners would be listed in the Proceedings as follows:

A Division Low Gross—Frank Mitchell, M.D., *Brunswick*

B Division Low Gross—M. H. Wylie, M.D., *Augusta*

C Division Low Net—M. Hobson Rice, *Decatur*

C Division Low Gross—William R. Edwards, Jr., M.D., *Atlanta*

Tennis Prizes

Dr. Train then called on Dr. Don Roberts, Chairman of the Tennis Tournament, to present the winners in that tournament as follows:

(Men)

Singles Winner—Joseph H. Dimon, III, M.D., *Atlanta*

Singles Runner Up—Irving Greenberg, M.D., *Atlanta*
 Doubles Winner—Joseph H. Dimon, III, M.D., *Atlanta*; Edgar D. Grady, M.D., *Atlanta*
 (Women)
 Single Winner: Dr. Lois Ellison, *Augusta*
 Singles Runner Up—Mrs. Ron Galloway, *Augusta*
 Doubles Winners—Dr. Lois Ellison and Mrs. Ron Galloway
 Doubles Runners Up—Mrs. Robert Tether, *Gainesville* and Mrs. Asher Newman, *Gainesville*

Art Exhibit Prizes

President Train then recognized Mrs. Marvin Engel, a member of the Art Exhibit Committee who, with the assistance of the Art Show judges, announced the following winners:

First—Water Color, Lola Josey (Mrs. John S.), *Brunswick*
 First—Oil, Beth Engel (Mrs. Marvin F.), *St. Simons*
 First—Sculpture, Libby Hertell (Mrs. Joseph A.), *Atlanta*
 First—Hobbies and Craft, Ruth Scoggins (Mrs. Paul T.), *Commerce*
 First—Children's Art, Jan Hertell (Daughter of Dr. Joseph A. Hertell), *Atlanta*

Medical Mile Award

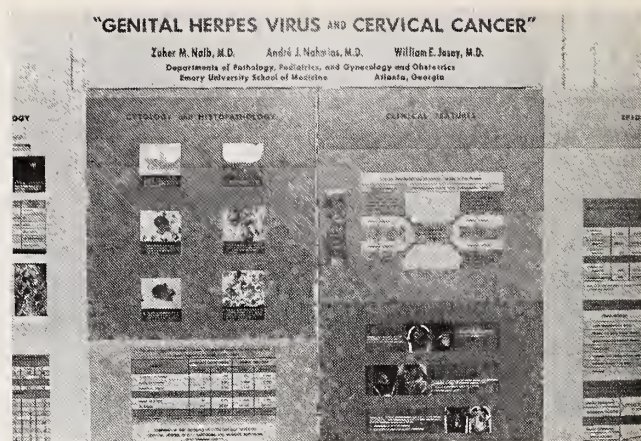
President Train then recognized Dr. Carson Burgsteiner, Chairman of the arrangements for the 1970 Medical Mile, who announced that Dr. Richard L. Benson, of Douglas, had won the 1970 Medical Mile in the record time of five minutes.

Civic Endeavor Award

President Train reminded the members present that the 1968 House of Delegates had created the Civic Endeavor Award to recognize outstanding public service and participation in civic activities. He then announced that the 1970 recipient was Dr. Noah D. Meadows, Jr., of Marietta.



Richard L. Benson, M.D., of Douglas, winner of the Medical Mile Award.



First Place Award, Scientific Exhibits, sponsored by Atlanta Drs. Naib, Nahmias, and Josey.

Hardman Cup Award

President Train then related the history of the Hardman Cup Award, which was established in May 1931 by Governor Lamartine Hardman, M.D., to recognize an outstanding discovery in medicine and surgery, or the solving of some particular problem in the field of public health. President Train advised the members present that there had been only 24 recipients of the Hardman Cup since 1931 but that the Secret Committee making the awards selection had chosen a recipient for 1970. Dr. Train then announced that the winner of the Hardman Cup Award was Dr. Beverly W. Forester, of Macon.

President Train then expressed his appreciation to the Medical Association of Georgia for the opportunity of serving as its President, and asked that President Elect F. G. Eldridge join him at the podium. Dr. Train then recognized the fact that Dr. Eldridge would be installed with the other officers of the Medical Association of Georgia at the General Business Session on Sunday, May 10, but stated that he wished symbolically to pass the gavel of office to Dr. Eldridge, as incoming President.

Dr. Eldridge received the gavel of office and expressed his appreciation to the Medical Association of Georgia for their trust, demonstrated by his election as President Elect.

Dr. Eldridge then turned the meeting over to the Master of Ceremonies, Dr. Train, who introduced the entertainment for the evening, "The Pearls of the Pacific."

Beware of language, for it is often a great cheat.
 —Peter Mere Latham

MAG General Session

(Third Session)

116th Annual Session of the Medical Association of Georgia

Sunday, May 10, 1970

THE THIRD GENERAL SESSION of the 116th Annual Session of the Medical Association of Georgia, Sunday, May 10, 1970, was called to order by President John Kirk Train, Jr., of Savannah, at 9:00 a.m., in Meeting Room B, Aquarama, Jekyll Island.

President Train called on the Reverend Dr. Paul B. McCleave, Director, AMA Department of Medicine and Religion, to lead the session in tribute to those members who had died since the May, 1969, Annual Session. The Reverend Dr. McCleave led the session in a brief religious observance and then read the names of those departed colleagues as follows:

H. M. S. Adams, Atlanta, November 31, 1969
Frank A. Blalock, Rome, July 8, 1969
Cecil D. Cason, Waycross, February 6, 1970
O. H. Cheek, Dublin, March 25, 1969
James J. Clark, Atlanta, August 15, 1969
H. E. Crow, Oakwood, October 30, 1969
Abe J. Davis, Augusta
Charles L. Davis, Atlanta, June 7, 1969
Guy J. Dillard, Columbus, June 4, 1969
W. S. Dorough, Atlanta, October 25, 1969
Robert Drane, Savannah, April 11, 1970
Mark S. Dougherty, Jr., Grand Island, Florida, May 1969
Thomas M. Ezzard, Roswell, April 26, 1970
I. A. Ferguson, Atlanta, February 26, 1970
Stephen E. Furst, Atlanta, April 10, 1970
Joseph E. Griffith, Marietta, April 3, 1969
O. S. Gross, Vidalia, March 1, 1969
W. W. Hillis, Jr., Millen, November 30, 1969
A. Robert Hornick, Augusta, March 17, 1969
A. B. Jones, Jr., Quitman, May 1969
Frank F. Kanthak, Atlanta, December 5, 1969
H. N. Kraft, Atlanta, March 5, 1970
Max Mass, Macon
Gene Nardin, Atlanta, April 11, 1970
L. G. Neal, Cleveland, August 1, 1969
W. Perrin Nicholson, Atlanta, July 12, 1969
J. H. Norton, Jr., Cave Springs, March 19, 1970
J. W. Palmer, Ailey, November 30, 1969
J. E. Penland, Waycross, November 20, 1969
W. E. Ragan, Jr., Atlanta, December 17, 1969
C. G. Redmond, Savannah, March 18, 1970
W. A. Selman, Atlanta, April 13, 1970
Henry P. Smith, Pearson, April 7, 1970

Stacy H. Story, Jr., Valdosta, August 19, 1969
William H. Trailer, Darier, January 18, 1970
John E. Walker, Columbus, June 7, 1969
Marcus L. Webb, Tifton, March 28, 1970
H. D. Youmans, Lyons, September 27, 1969
S. S. Youmans, Swainsboro
George P. Sassos, Mount Vernon, February 4, 1970

Certificates of Appreciation

President Train then recognized the MAG Secretary, John Rhodes Haverty, M.D., to present MAG Certificates of Appreciation to individuals deserving of special recognition for their contributions to medicine as follows:

John Kirk Train, Jr., M.D., as MAG President, 1969-1970; John S. Atwater, M.D., as MAG Treasurer, 1969-1970; Mrs. Mary Helen Goodloe, for service to the School Child Health Committee in the Field of Nutrition, 1969-1970; T. A. Sappington, M.D., as Chairman of the MAG Committee on Professional Conduct and Medical Ethics, 1969-1970; Mr. H. W. Wallace, for service to the state of Georgia in the Mental Health Field; Mr. C. J. Thurmond, for service to the State of Georgia in the Mental Health Field; Alex P. Jones, M.D., as Chairman of the MAG Committee on Hospital Activities, 1968-1970; Mrs. Talitha M. Russell, for Legislative Assistance to the Medical Association of Georgia, 1970; Thomas N. Lumsden, M.D., as Chairman of the MAG Committee on Rural Health, 1963-1970; Representative Bill Williams (presented by Dr. Robert Ewells), for outstanding contributions to Traffic Safety; and Senator Cyrus M. Chapman (presented by Dr. Harrison L. Rogers), for outstanding leadership in the field of health legislation.

Fifty Year Awards

President Train recognized MAG Second Vice President, F. William Dowda, who presented Fifty Year Certificates to members who were graduated from medical school and licensed to practice 50 years ago.

H. D. Allen, M.D., *Milledgeville*; Joseph D. Applewhite, M.D., *Macon*; Charles S. Britt, M.D., *Brunswick*; James J. Clark, M.D., *Atlanta*; Grady N. Coker, *Canton*; Tom F. Davenport, M.D., *Atlanta*; Milton T. Edgerton, M.D., *Atlanta*; Earl H. Floyd,

M.D., *Atlanta*; J. Dewey Gray, M.D., *Augusta*; John T. King, M.D., *Thomasville*; Joseph H. Kite, M.D., *Atlanta*; John C. O'Neill, M.D., *Savannah* and H. G. Weaver, M.D., *Macon*.

Life Membership Awards

Dr. Ronald F. Galloway, MAG First Vice President, was recognized by President Train to present special gold membership cards to MAG Life Members.

James H. Byram, *Atlanta*; Cecil N. Brannen, *Montreal*; T. J. Busey, *Fayetteville*; William M. Cason, *Atlanta*; Leila D. Denmark, *Atlanta*; Laurence B. Dunn, *Savannah*; F. D. Funderburg, *Monticello*; J. D. Gray, *Augusta*; Zach W. Jackson, *Atlanta*; Ellen F. Kiser, *Atlanta*; William H. Kiser, Jr., *Atlanta*; W. V. Long, *Savannah*; Joseph C. Massee, *Atlanta*; H. G. Mealing, *Augusta*; Jack C. Norris, *Atlanta*; Irvine Phinzy, *Augusta*; Vernon E. Powell, *Atlanta*; Calvin Sandison, *Atlanta*; William A. Smith, *Atlanta*; Trammell Starr, *Dalton*; Ebert Van Buren, *Atlanta*; William C. Warren, Jr., *Atlanta*; J. N. Willis, *Columbus*; Richard Wilson, *Atlanta*; and Charles Zimmerman, *Tifton*.

GaMPAC Awards

Dr. Luther M. Vinton, of Decatur, Chairman of the Georgia Medical Political Action Committee, was then recognized by President Train for the purpose of awarding plaques in three categories of outstanding contributions to the PAC movement.

Highest Percentage of County Membership—Upson County

Highest Percentage of District Membership—4th Congressional District

Highest Total Dollar Contribution—DeKalb County



Luther M. Vinton, M.D., presents GaMPAC award to T. A. Sappington, M.D., of Upson County, for Highest Percentage of County Membership.

Distinguished Service Award

President Train then stated that the highest honor that the Medical Association of Georgia could be-

stow in recognition of service to MAG was the Distinguished Service Award. He further explained that this was not necessarily an annual award but was given only when some member deserved such by serving the Association far above and beyond the call. Dr. Train then announced that a secret committee had selected as the 1970 recipient of the Distinguished Service Award, Dr. Tom W. Goodwin, of Augusta, and asked that the members present give Dr. Goodwin a rising vote of applause as he came forward to receive the Award.

Future Annual Session Sites

President Train then called for any invitations from county societies for future sites of Annual Sessions of the Medical Association of Georgia. Dr. Train reminded the members of the General Session that the 1971 meeting would be held in Atlanta, the 1972 meeting in Macon, and the 1973 meeting in Augusta. President Train then recognized Dr. Franklyn P. Bousquet, Jr., of Savannah, who presented a resolution of the Georgia Medical Society and a letter from the Mayor of the City of Savannah, as follows:

To the Distinguished Members of the Medical Association of Georgia:

The Georgia Medical Society—comprised of the counties of Chatham, Effingham, Liberty, Long and McIntosh, and the oldest medical society in the state, having been organized in 1804—has the greatest of pleasure in extending to the Medical Association of Georgia a cordial invitation to hold its 1974 annual meeting in the city of Savannah.

This Society has enjoyed its role as host to the physicians of the state of Georgia many times in the past. It has been the source of pride not only to the Society but to the city of Savannah and Chatham County to have the members of the Medical Association of Georgia foregather as our guests. We shall take pride in having the Medical Association of Georgia once again in our midst and expect to place at its disposal as fine convention facilities as are available in the state of Georgia.

It is our hope that this sincerely extended invitation will be accepted by the Medical Association of Georgia.

Lawrence Lee, Jr., M.D.

President

Harry H. McGee, Jr., M.D.

Secretary

Dear Members of the Medical Association of Georgia:

I would like to extend to you all a warm invitation to hold the 1974 meeting of the Medical Association of Georgia in the city of Savannah. It would be an honor to have you here and you would be made very welcome by our citizens.

As you know, Savannah is the oldest city in Georgia and offers visitors the unique experience of enjoying something of the leisured pace of the historic South while losing none of the advantages of modern

civilization. We are now constructing a sophisticated Civic Center complex which will be completed next year and will afford every facility and convenience for meetings such as your own.

Please make plans to come to Savannah in 1974 and give us the pleasure of showing you why our city is renowned throughout the nation as being the Hostess City of the South.

*Sincerely,
J. Curtis Lewis, Jr.
Mayor*

Dr. Bousquet then moved that the Medical Association of Georgia accept the invitation of the Georgia Medical Society to hold its 1974 meeting in the City of Savannah. This motion was duly seconded and passed.

President Train then recognized Dr. F. William Dowda, President of the Fulton County Medical Society, who extended an invitation to the Medical Association of Georgia to hold its 1975 Annual Session in Atlanta. On motion duly made and seconded, the General Session voted to accept the invitation of the Fulton County Medical Society.

At this point, President Train announced that the



President Train presents the 1970 Distinguished Service Award to Tom W. Goodwin, M.D.

Third General Session was now recessed and turned the gavel over to the Speaker of the MAG House of Delegates, Dr. Harrison L. Rogers, to convene the Second Session of the MAG House of Delegates in conjunction with the 116th Annual Session.

Second Session, House of Delegates

Sunday, May 10, 1970

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia, held in conjunction with the 116th Annual Session of the Association, was called to order by Speaker Harrison L. Rogers, at 9:45 a.m., in Meeting Room B, Aquarama, Jekyll Island, Georgia, on May 10, 1970.

Speaker Rogers called for the report on attendance from the Credentials Committee. Dr. Robert Moye, Chairman of the Credentials Committee, reported that over forty (40) Delegates were present and accounted for and that since forty (40) members of the House constituted a quorum, business could proceed. Speaker Rogers declared a quorum present and the House of Delegates duly in Session. The Credentials Committee made the following complete report on attendance at the close of the meeting.

Attendance

In a compilation of attendance taken from the official roll, 39 county medical societies were presented by their duly elected delegates or alternates. Of a total of 163 authorized delegates by their respec-

tive medical societies, the official roll showed 118 delegates present at this Second Session.

ALTAMAHA: E. J. Virusky; BIBB: Charles G. Burton; Henry C. Drake; Charles A. Lanford; A. L. Mayes, Jr.; Henry H. Tift; Alexander H. S. Weaver; OGEECHEE RIVER: Leon E. Curry; CARROLL-DOUGLAS-HARALSON: J. L. Boss; Phil C. Astin; GEORGIA MEDICAL SOCIETY: F. P. Bousquet; J. Patrick Evans; Robert Logan; F. Debelc Maner; Edwin C. Shepherd; Alton F. Williams; CHATTAHOOCHEE: Rupert H. Bramblett; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald Branyon; F. M. McElhannon; CLAYTON-FAYETTE: Wells Riley; COBB: Remer Y. Clark; Luther G. Fortson; James H. Manning; Stephen C. May; Noah D. Meadows; Donald R. Rooney; COFFEE: R. L. Benson; DEKALB: Stanley P. Aldridge; William Belcher; John P. Heard; Ellis B. Keener; M. Hobson Rice; Roger R. Rowell; O. W. Stubbs, Jr.; Luther M. Vinton; Knox Walker, Jr.; DOUGHERTY: J. D. Bateman; C. D. Hollis; Robert Waller; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: W. Henry Lucas; Jack R. Meacham; Harold G. Robinson; James H. Smith; FULTON: Thomas J. Anderson, Jr.; John S. Atwater; Allan Bleich; Spencer S. Brewer; F. William Dowda; Edwin C. Evans; Henry M. Finch; Robert F. Finegan; Joseph L. Girardeau;

Irving L. Greenberg; Chenault W. Hailey; L. Harvey Hamff; J. Harold Harrison; J. Rhodes Havery; Joseph Hertell; William E. Huger, Jr.; James A. Kaufmann; J. Watts Lipscomb; William D. Logan; J. G. McDaniel; William L. McDougall, Jr.; C. R. Moorhead; Neil G. Perkinson; A. A. Rayle, Jr.; Harrison L. Rogers; John Schellack; Hugh S. Thompson, Jr.; Charles E. Todd; L. Newton Turk, III; J. Frank Walker; Robert E. Wells; Frank L. Wilson, Jr.; Joseph S. Wilson; GLYNN: C. A. Wilson; HABERSHAM: Tom Lumsden; HALL: A. Fred Bloodworth; C. W. Whitworth; PEACH BELT: Virgle W. McEver; JACKSON-BANKS: E. W. Holloway; LAURENS: W. M. Watkins; McDUFFIE: Thomas E. Averitt; MERIWETHER-HARRIS: J. Emmett Collins; MUSCOGEE: Henry H. Boyter; T. Jack McGee; Luther J. Smith; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: William E. Barfield; Preston D. Ellington; William A. Fuller; Menard Ihnen; Julius T. Johnson; J. Kenneth McDonald; Stuart H. Prather, Jr.; Henry D. Scoggins; Walter L. Sheppard; SOUTH GEORGIA: H. B. Smith; Joe Stubbs; SPALDING: Alex P. Jones; SUMTER: J. H. Robinson, III; THOMAS-BROOKS-GRADY: Thomas Lear; Frank Miller; TROUP: Charles T. Cowart; Alvah J. Nelson; WALKER-CATOOSA-DADE: Robert Jones; F. J. Smiley; UPSON: T. A. Sappington; WALTON: Byron Harper; WARE: S. W. Clark; Floyd E. Davis; WAYNE: O. O. McGahee; WHITFIELD: E. T. McGhee; WILKES: M. C. Adair.

Election of Delegates

Speaker Rogers then announced that at this time the House would elect the officers for the coming year and two Delegates and Alternates to the American Medical Association for the term January 1, 1971 to December 31, 1972. Since there were no contested races this year, Speaker Rogers read the list of duly nominated candidates as follows:

President-Elect—W. C. Mitchell, M.D., *Smyrna*
 Second Vice President—Henry D. Scoggins, M.D., *Augusta*
 AMA—Delegate—Frank Walker, M.D., *Atlanta*
 AMA Delegate—Preston D. Ellington, M.D., *Augusta*
 AMA Alternate Delegate—J. D. Bateman, M.D., *Albany*
 AMA Alternate Delegate—F. William Dowda, M.D., *Atlanta*

On motion duly made and seconded, the slate of Officers, Delegates, and Alternates as read was unanimously elected.

Speaker Rogers then called for reports from the Reference Committee Chairmen. Speaker Rogers explained that the matter of business as introduced would be considered the motion of the floor, and that if no discussion or dissent followed each portion of the Reference Committee Report, he would rule the item adopted as introduced. However, in the event that a Reference Committee amended a report or presented a substitute, the House should consider it the motion before the House. Speaker Rogers

explained that the Chair would rule each item adopted pending final vote on the entire report of each Reference Committee.

Report of Reference Committee A

W. Henry Lucas, M.D., Chairman

Chairman Lucas reported to the House that reports and resolutions as referred to Reference Committee A had been considered by the Committee which convened at 9:00 a.m., in Coach Room A, Carriage Inn, Jekyll Island, on May 9, 1970. Members of the Committee present included W. Henry Lucas, M.D., Rome, Chairman; Phil C. Astin, M.D., Carrollton, Vice Chairman; Henry D. Scoggins, M.D., Augusta; William D. Logan, M.D., Atlanta and C. D. Hillis, M.D., Albany.

Speaker of the House of Delegates

HARRISON L. ROGERS, JR., M.D., *Atlanta*

Your Speaker and Vice Speaker have seen the benefits of the innovations brought to the House in the past few years. The mechanical operation of the House is smooth and works to the best advantage of the Association. All business referred to the House is duplicated and sent to the Delegates well in advance of the Annual Session for their consideration as well as that of their constituent societies. Next, during the deliberations of the Reference Committee to which a particular item of business has been referred by your Speaker, all members and Delegates have ample opportunity for debate. Finally as the Reference Committee recommendations reach the House for discussion, debate and adoption or rejection, the Delegates again have complete freedom in their evaluation of the individual item.

Thus, as described, the mechanics of operation of your House of Delegates are in good order. It is with considerable despair, therefore, that I hear of surprise or dissatisfaction with the decisions reached, by the general membership of the Association. Not only does this occur, but we have many members who have no conception of how the House of Delegates, our legislative arm of the Association, operates. The smooth mechanics described above are a complete mystery to the majority of our members. To say this is the only area of our lives where the operation of an organization (whether church, Hospital Staff, or Governmental Unit) to which we belong is a mystery, would be an untruth. This makes our lack of knowledge of and interest in the Medical Association of Georgia no more acceptable. I for one do not accept it and intend to do all in my power to change it.

I want our Delegates to occupy sought after and contested seats—for these seats are truly representative of each member of our Association. The Delegates have made and will continue to make decisions which affect the practice of each of us everyday. Furthermore, I want our component societies to consider all available material before as well as during the House meetings and then after the Annual Session is over to take the Actions of the House back to their constituents.

RECOMMENDATIONS

(1) That the House take cognizance of its responsibility to the members of the Association not only to

make the necessary decisions, but to insist that these decisions are well disseminated to the members.

(2) That some means be devised, either by mandatory indoctrination meetings or by an avalanche of written information, to be certain that every new member of our Association is familiar with the mechanics by which we operate.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of Recommendation (1) and also Recommendation (2) with the deletion of the word “mandatory” in Recommendation (2) and the words “an avalanche of” also in Recommendation (2), so that the Recommendation would read as follows:

“(2) That some means be devised, either by indoctrination meetings or by written information, to be certain that every new member of our Association is familiar with the mechanics by which we operate.”

HOUSE OF DELEGATES ACTION—Adopted the Report of the Speaker of the House of Delegates with the changes recommended by the Reference Committee.

Vice Speaker, House of Delegates

PRESTON D. ELLINGTON, M.D., *Augusta*

As Vice Speaker of the House of Delegates of the Medical Association of Georgia, my time and my services have been available to the Speaker at all times during this past year to be used at his discretion in all matters concerning the House of Delegates.

I attended the Southeastern Speakers Conference in New Orleans on February 21-22, 1970. Dr. Russell Roth, Speaker, House of Delegates of the AMA and Dr. J. Frank Walker, Vice-Speaker, House of Delegates, AMA, were principal speakers. This conference is designed for the exchange of ideas to improve efficiency and effectiveness of state medical association meetings. We are continuing the “loose leaf” handbook, the pre-registration of Delegates and a reserved section with work tables for the Delegates in the General Assembly room. We are also including dividers for the notebooks this year. Your Speaker and I will continue to seek means to further facilitate the work of this House of Delegates.

It has been my privilege to serve as Vice Speaker of the House of Delegates this year.

RECOMMENDATION

Because of the great educational value, I recommend that the expenses of the Speaker and the Vice-Speaker of the Medical Association of Georgia be paid by the Medical Association of Georgia to attend the annual Southeastern Speakers Conference. This House conducts its business and deliberations by tradition, custom, and parliamentary reference. I recommend that this House adopt “Standard Code of Parliamentary Procedure” by Mrs. Alice Sturgis as the parliamentary reference instead of *Robert’s Rules of Order*, Revised, and instruct the Committee on Constitution and Bylaws to prepare such changes in the Bylaws of this Association for adoption by this House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION
—The Reference Committee recommends disapproval of the recommendation that the expenses of the

Speaker and the Vice Speaker of the Medical Association of Georgia House of Delegates be paid by the Medical Association of Georgia to attend the Annual Southeastern Speaker’s Conference. Your Reference Committee recommends approval of the recommendation that the House of Delegates adopt “Standard Code of Parliamentary Procedure” by Mrs. Alice Sturgis as a parliamentary procedure reference instead of “Robert’s Rules of Order, Revised,” and instruct the Committee on Constitution and Bylaws to prepare such changes in the Bylaws of the Association for adoption by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Vice Speaker of the House of Delegates with the changes recommended by the Reference Committee.

Woman’s Auxiliary Advisory Committee

W. C. MITCHELL, M.D., *Chairman*

The Chairman, along with the members of the Advisory Committee, met with the Woman’s Auxiliary at the planning conference for the Medical Association of Georgia committees in June. The Auxiliary this year planned their workshop to coincide with this meeting and, to me, this seemed an excellent idea, as the attendance was much better than it had been previously and it was easier to take care of matters of mutual concern.

Mrs. Sue Clark, President of the Woman’s Auxiliary, has been present at all of our Council meetings. She has always been a most welcome guest and on these occasions the Chairman and members of Council present were briefed on the Auxiliary’s business as well as any plans that were in the making.

I marvelled in the past at the amount of work that these good ladies accomplish and they add more and more to their load every year. The joint committees have helped the Medical Association of Georgia. I’m sure, and I urge that these be continued and expanded.

The room in the headquarters building which was set aside for the use of the Auxiliary as a central location for their records, trophies, and items that need to be saved, makes them feel wanted. I trust it will remain as is for their use.

RECOMMENDATIONS

Continue to encourage them in their efforts and to seek their help in matters of public relations. ‘Cause, “Who Needs More and Better Public Relations?” We Do.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of the Report with Commendation.

HOUSE OF DELEGATES ACTION—Adopted the Report as recommended by the Reference Committee.

Maternal and Infant Welfare Committee

EUGENE L. GRIFFIN, M.D., *Chairman*

Under the chairmanship of Dr. Eugene Griffin this committee met four times in 1969. The committee studied in detail every maternal death from information obtained by the committee. It also concerned itself with other matters pertaining to maternal and in-

fant health in the state of Georgia. Major areas of activities are listed in brief.

LIVEBIRTHS AND BIRTH RATE—There were 87,323 livebirths in 1968, and the birth rate of 191 is the lowest in over 40 years. (Preliminary data indicate there were between 89,000 and 90,000 livebirths in 1969.) Hospital deliveries have reached a high of 94.5 per cent which compares with a rate of 93.3 per cent in the previous year.

MIDWIFE ACTIVITIES—There were 4,054 (4.6 per cent) livebirths delivered at home by midwives in 1969. This was 835 or 17.1 per cent less than the previous year. In 1968, 1,036 hospital deliveries were paid for under Medicaid (Title XIX). It is hoped that all midwife deliveries as now conceived will be eliminated.

MATERNAL MORTALITIES—There were 30 maternal deaths in Georgia in 1968, out of a total of 87,323 livebirths. The maternal death rate was 3.4 per 10,000 livebirths, which compared with a rate of 3.2 in 1967. The leading cause was toxemia (7). Ectopic pregnancy, hemorrhage and abortion were each responsible for five deaths. Three were due to infection and a total of five were related to other complications of pregnancy and childbirth.

IMMATURE BIRTHS—In 1968 there were 8,261 immature livebirths (99 more than in 1967) for a rate of 94.6 per 1,000 live births. Immature livebirths occur approximately twice as frequently in the non-white livebirths as in the white. It is significant that immaturity occurs much more frequently in livebirths to the mother under 18 in both races.

Percent of Immature Livebirths—1968

	1968
White	7.3
Nonwhite	13.8
White Under 18	10.9
White 18 to 39	6.9
Nonwhite Under 18	17.3
Nonwhite 18 to 39	13.2

BIRTHS TO UNWED MOTHERS—There were 10,046 livebirths to unwed mothers, an increase of 62 over 1967. The rate was down from 115.5 in 1967 to 115.0 (1968). Livebirths to white unwed mothers (2,112) increased 230; and livebirths to unwed non-white mothers (7,934) decreased 168 from the previous year. Immaturity is significantly influenced by marital status, both generally and racially.

Percent of Immature Livebirths—1968

Married	8.8
Unmarried	14.2
White Married	7.1
White Unmarried	11.1
Nonwhite Married	13.1
Nonwhite Unmarried	15.0

LIVEBIRTHS TO GRAND MULTIPARA—A total of 6,450 livebirths (7.4 per cent) were in the order of 6th and over. In 1967 there had been 8,123 (9.5 per cent) livebirths in the order of 6th and over. There has been a steady decline in births in the order of 6th

and over from the 13.1 per cent which occurred in 1960. This decline has been most marked in the past two years.

NUTRITION—All counties have surplus commodities available or have Food Stamp programs. Five counties now offer the supplementary food program for those most vulnerable to malnutrition (i.e., pregnant women, lactating mothers, infants and preschool aged children). Nine other counties have applied but as yet have not been approved by the State Food Distribution office.

PERINATAL MORBIDITY AND MORTALITY—This subcommittee recommended to the state Society that the birth certificate now being used be modified to contain medical information which could be tabulated as is done by all other states except Georgia and Massachusetts. This tabulated information could then be used to polarize on certain areas of greatest risk to the foetus and an effort made to eliminate the areas of risk. The state Association backed the request. Unfortunately, the State Board of Health, upon advice from the Department of Health, turned down this request. It is regrettable that such a backward step would be taken at this time. It is our hope that the State Board of Health at some time in the near future will reconsider the entire matter and assist this committee with this vital problem.

THERAPEUTIC ABORTION LAW—On April 12, 1968, the Therapeutic Abortion Act became law. From that date until December 31, 1968, a total of 241 therapeutic abortions have been reported, as required by law, to the Director of the Department of Public Health. A total of 177 were performed for maternal indications, 53 for fetal indications and 11 for rape.

The last state legislature considered a more liberal Therapeutic Abortion Law introduced by representative Kil Townsend. This liberalized law, however, was referred back to a sub-committee for further study and it is almost certain that a new liberalized law will be introduced at the next session. It is the committee's feeling that in order for us to properly testify at the next legislative session, that a more accurate account of the feelings of the doctors of Georgia be obtained concerning Therapeutic Abortion.

FAMILY PLANNING—The committee has given active support to local and statewide family planning programs. The intrauterine contraceptive device has been well received in the state Program. The state data collection computerized evaluation system indicates there were 26,922 women actively participating in the State Health Department program as of December 31, 1969 (1968 = 20,502). This estimate is based upon proven, continuous active contraceptors by current records. The number is conservative as it does not include a large number who received service before instituting the current record system, and who may well be continuing. The significant drop in births in the birth order of sixth and beyond may be attributed to a large extent to family planning.

STERILIZATION LAW—A modification of the 1966 Sterilization Law was passed by the State Legislature at its last session upon recommendation and guidance of this committee. These modifications in es-

sence allow sterilization of the female if the husband cannot be located after reasonable effort. The new law also supplants the old Eugenic Sterilization Act which was never used and sets forth certain specifications which, if properly met, will allow the doctors of the state to do sterilizations for eugenic purposes. It is our hope and belief that this new law will prove to be a real value to the practicing physicians of this state.

CERVICAL CANCER SCREENING PROGRAM

—The committee has actively supported the establishment and conduct of a statewide cervical cancer screening program sponsored by the Georgia Department of Public Health. The program offers Pap smears to indigent and medically indigent patients receiving health services in local health departments. From February 1, 1967, through December 31, 1969, 53,333 Pap smears were done, 24,564 during 1969. There were 574 women having suspicious or positive Pap smears. Follow-up is completed on 510 of these patients, showing 351 to have benign and 159 to have malignant lesions. Of significance is the fact that 129 (81 per cent) cases were diagnosed and treated for preinvasive and 30 (19 per cent) were diagnosed and treated for invasive carcinoma of the cervix. According to the most recent report of the United States Public Health Service Cancer Control Program, 43 per cent of the women in Georgia had a Pap Smear in 1966. This percentage was only exceeded by the District of Columbia with 65 per cent of the females examined in 1966.

RECOMMENDATIONS

1. That the Medical Association of Georgia, through proper channels, authorize and allocate funds for a mass survey of all physicians of the state concerning their feeling about Therapeutic Abortion, which survey can be used to guide this committee and the legislative committee during the next legislative session concerning this vital question.

2. That the Medical Association go on record as being deeply disappointed that the State Board of Health turned down its recommendation that Birth Certificates be modified so as to include much needed medical information. It further expresses the hope that this matter may be reconsidered in a more favorable light at a later date.

REFERENCE COMMITTEE RECOMMENDATION

—Your Reference Committee approves the intent of the recommendation (1) when changed to read as follows:

“(1) That the Medical Association of Georgia through proper channels authorize and allocate funds not to exceed \$500.00 for a mass survey of all active MAG physicians concerning their feeling about Therapeutic Abortion, which survey can be used to guide the Maternal and Infant Welfare Committee and the Legislative Committee during the next legislative session concerning this vital question.”

The Reference Committee recommends approval of Recommendation (2).

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Maternal and Infant Welfare with the changes recommended by the Reference Committee.

Nursing Liaison Committee

CHARLES EBERHART, M.D., *Chairman*

At the 1969 meeting of the MAG House of Delegates a resolution was passed to investigate the adequacy of nursing education. This was Resolution 69-5, Nursing Education, and is quoted below:

“WHEREAS, there have been dramatic changes in Nursing Education in the past recent years, and

“WHEREAS, involvement of organized medicine has been less than adequate in planning and implementation of the same, and

“WHEREAS, we are concerned as to the quality and effectiveness of such education and practicality in real situations, and

“WHEREAS, each nurse in Georgia acts under direct authority of and responsibility to the individual practicing physician in patient care,

“THEREFORE BE IT RESOLVED, that the Medical Association of Georgia cause to be formed such committees as necessary to inform itself as to present Nursing School Curriculum and further evaluate each of the types of schools as to its practicality and effectiveness in producing diplomates skilled in personal patient care, and

“FURTHER BE IT RESOLVED, that such study be presented to this body sufficiently prior to the next Annual Session so that it might make effective recommendations to responsible parties.”

Our committee was given the task of evaluating the types of nursing schools and to make a report at the 1970 Annual Session.

Upon reflection several considerations contradict this action: (1) The investigation should be conducted by persons trained in the field of education; (2) Funds are not available for an extensive survey; (3) An investigation by this committee would probably be meaningless to anyone except the physicians; and (4) The requirements of the State Board for Nursing would have to be changed, as the present educational requirements are inadequate as indicated by the high failure rate.

RECOMMENDATION

After due consideration, the Nursing Liaison Committee feels it wise to delay action this year on the 1969 resolution, and to render a report next year.

REFERENCE COMMITTEE RECOMMENDATION

—Your Reference Committee approves the Nursing Liaison Committee's recommendation.

HOUSE OF DELEGATES ACTION—Adopted the Report of the Committee on Nursing Liaison as recommended by the Reference Committee.

Resolution 70-2

Election Procedure of the General Practitioner of the Year

DEKALB COUNTY MEDICAL SOCIETY

WHEREAS, the selection of The General Practitioner of the Year bestows much well-deserved honor upon the recipient; and

WHEREAS, frequently more than one nominee is obviously well-deserving of the award; and

WHEREAS, there is also insufficient time due to the press of other business for each delegate to personally evaluate the nominees; and

WHEREAS, there must be a loser under the present selection system by the House of Delegates unjustly and publicly implying lack of qualification,

THEREFORE BE IT RESOLVED, that the Board of Trustees of the Georgia Academy of General Practice be delegated the responsibility of the selection of the General Practitioner of the Year; and

BE IT FURTHER RESOLVED, that the award be presented with appropriate ceremony at the initial session of the MAG convention each year.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee approves the Resolution with the editorial correction changing the word "Trustees" to "Directors."

HOUSE OF DELEGATES ACTION—Adopted Resolution 70-2 with the change recommended by the Reference Committee.

Resolution 70-4

Abortion Laws

BIBB COUNTY MEDICAL SOCIETY

BE IT RESOLVED, that the Medical Association of Georgia should support efforts in the 1971 General Assembly to revise and liberalize the abortion laws of the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee approves this resolution with certain changes, so that it would read as follows:

"BE IT RESOLVED, that the Medical Association of Georgia should support efforts in the 1971 General Assembly to revise and liberalize the abortion laws of the State of Georgia, if the proposed survey of the MAG active members so indicates."

HOUSE OF DELEGATES ACTION—Rejected Resolution 70-4 by adopting a motion from the floor that this matter be turned over to the Council for handling at its own discretion.

Resolution 70-16

Medicaid Payment for Sterilization

CRAWFORD W. LONG MEDICAL SOCIETY

WHEREAS, there is considerable evidence that a continuation of present birth rates will lead to overpopulation; and

WHEREAS, population control is accepted by many levels of government as a legitimate concern of those governments; and

WHEREAS, ligation of vasa deferentia in males and Fallopian tubes in females is a most effective means of producing sterility; and

WHEREAS, medically indigent persons who desire no more children are often unable to afford the cost of these operations; therefore be it

RESOLVED, that the Medical Association of Georgia be in favor of extending Medicaid payments to cover the cost of voluntary sterilization of men and women otherwise eligible for Medicaid; and

BE IT FURTHER RESOLVED, that the Medical

Association of Georgia exert its influence towards procuring medical payments for these procedures.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee approves the Resolution with the deletion of the word "otherwise" in the first RESOLVED.

HOUSE OF DELEGATES ACTION—Adopted Resolution 70-16 with the change recommended by the Reference Committee.

Chairman Lucas then stated that he wished to thank the members of Reference Committee A for their time and effort and moved that the Committee Report be adopted as a whole. This motion was duly seconded and approved.

Report of Reference Committee B

John G. Bates, M.D., Chairman

Chairman Bates reported to the House that the reports and resolutions referred to Reference Committee B were considered by the Committee which met at 9:00 a.m., in Coach Room B, Carriage Inn, on May 9, 1970. Members of the Committee present were: John G. Bates, M.D., Cuthbert, Chairman; Noah D. Meadows, M.D., Marietta, Vice Chairman; William L. McDougall, M.D., Atlanta; Thomas E. Averitt, M.D., Thomson; Luther J. Smith, M.D., Columbus and Ellis B. Keener, M.D., Decatur.

Chairman Bates reported that in addition to a few broad recommendations, Reference Committee B had before it those matters of business dealing with the finances of the Association and the employed staff of the Association. For clarification and simplicity the Reference Committee considered those reports together which deal with a specific subject and wished to present its recommendations to the House in that manner.

First Vice-President

RONALD F. GALLOWAY, M.D., Augusta

In view of the considerable discussion and controversy arising from the 1969 House of Delegates action in which a one year dues increase of \$100.00 was levied, I anticipate that further views on this matter will be expressed at the 1970 Annual Session.

Out of the smoke and fire which is likely to occur, I sincerely hope that at least two pertinent facts will emerge:

(1) Medical Association of Georgia dues of \$40.00 yearly are the nation's lowest.

(2) The Medical Association of Georgia cannot continue to be as active unless an increase in dues is enacted.

RECOMMENDATIONS

(1) That the House of Delegates, through proper steps, initiate an increase in the annual dues at the 1970 Annual Session.

(2) That the Executive Committee of Council, the Council, the Finance Committee, and the House of Delegates remain aware of the increasing future needs for financial support of our association and thereby avoid, if possible, the need for a large one-year dues increase as was felt by the House of Delegates to be necessary in 1969.



Dr. Paul H. Knappenberger of the Fernbank Science Center, Atlanta, participating in the panel discussion on "Man, Moon and Medicine."

Chairman of Council

CHARLES EMORY BOHLER, M.D., *Brooklet*

As Chairman of the Council for the year 1969-70 I am pleased to make the following report to the MAG House of Delegates as a brief review of some of the actions taken by Council during this period. It is not intended as a detailed accounting as the full text of all minutes of meeting of Council are published routinely in the *Journal of the Medical Association of Georgia* and are always available to any member on request.

Perhaps it would be sufficient to state that the prime function of the Council during the past 12 months has been to assure, as well as possible, that the recommendations of the 1969 House of Delegates have been carried out and that all new items of business presented to Council have been disposed of in a manner that would be well received by the House.

However, several actions of the Council merit more detailed mention here. No attempt will be made to list such matters either chronologically or in order of importance by your Chairman.

MAG HEADQUARTERS BUILDING

In December, 1969, the Council formally received the new MAG headquarters building from the architects. The new building is one in which the entire profession can take a measure of justifiable pride. For the first time in several years our Association can operate from quarters that are not only functionally suitable to the task, but also reflect the dignity of the profession, adequately symbolize the progress made in the past, and assure us of a Headquarters Building from which we can grow to meet the needs of the future.

COMMITTEE CONCLAVES

Council reviewed the value of past Committee Conclaves and approved their continuation in the future as a move to strengthen the MAG Committee system.

PHYSICIAN-LAWYER CODE OF COOPERATION

Approval was given to a completely re-written Code

of Cooperation for practitioners of medicine and law, and a subsequent distribution of this document was made.

LIAISON WITH STATE BOARD OF HEALTH

The Council has continued the practice of exchanging representatives with the Board of Health at all meetings of the Council and Board. This practice, started some years ago, has greatly improved our rapport with the Board and significantly enhanced mutual cooperation to the benefit of both groups.

MEDICAL EXAMINER SYSTEM FOR GEORGIA SEMINAR

Council endorsed the concept of a seminar on the matter of a "Medical Examiner System for Georgia" that was held by the Georgia Association of Pathologists. As presented, it was felt that such a seminar might be the beginning of a legislative campaign to repeal the coroner system and institute the medical examiner system on a statewide basis.

CLINICAL LABORATORY INSPECTION

In the field of inspection of physician's office laboratories, the Council endorsed the concept of "peer review" as opposed to review and inspection by a state agency. The Council further urged compliance by individual physicians by encouraging the furtherance of the Proficiency Evaluation Program of the College of American Pathologists.

MEDICAID PROGRAM PEER REVIEW

Council appointed a committee to develop a system of "peer review" for the Medicaid program and instructed the committee to work with the Board of Health on this matter.

STATEWIDE BIRTH CONTROL PLAN

Council authorized the President to appoint a committee to work with Representative George Busbee of Albany on the development of a voluntary "birth control" plan that could be applied statewide.

NATIONAL AND STATE LEGISLATION

Legislatively, the Council received continuous reports on the status of pending bills and sought to advise the Legislative Committee on the proper Association position and appropriate course of action to be taken.

HIMLER REPORT

Council approved extensive amendments to a report to be presented to the AMA House of Delegates in June, 1970. This document, known as the Himler Report, contains 20 detailed recommendations relating generally to the system of the delivery of health care. Amendments to this report are submitted as Council Resolutions for the information of the House of Delegates.

AMA MEDI-CREDIT PLAN

Council endorsed the AMA alternative to National Health Insurance known as the "Medi-Credit" plan. Under this plan an individual taxpayer would receive an income tax credit based on his tax liability for the

purchase of qualified health insurance from a private carrier.

DUES ASSESSMENT

Lastly, permit me to relate the actions of the Council on the matter of the \$100 additional dues for 1969 as imposed on the membership by action of the 1969 House of Delegates.

As you will recall, adoption of this matter by the 1969 House provided that \$100 additional dues for 1969 were to be levied and that September 1, 1969, was to have been the "cut-off" date.

At the September meeting of Council it was disclosed that a number of members had not yet remitted their \$100. Council did not feel that it could, in good conscience, revoke the MAG memberships of so large a number of dedicated physicians. Accordingly, it voted to instruct the Headquarters staff to continue sending monthly statements until December 1969.

At the December meeting, although the problem had been greatly reduced, there were nonetheless a significant number of members who had not yet paid their 1969 additional dues. At this point the desire on the part of many of these physicians to maintain their MAG membership was clearly evident by reasons of the fact that their regular dues for 1970 were being received.

I want to take this opportunity to thank all the members of Council for their splendid cooperation during the past year. Their dedication to the often "thankless task" of administering the affairs of the Association has been a source of inspiration to me personally as well as a source of true strength to organized medicine in Georgia. I further want to acknowledge an unpaid debt to the MAG Auxiliary under the inspired leadership of Mrs. Sue Clark. Without the help of Mrs. Clark, the Auxiliary, and each member of Council, progress during the year 1969-70 would have been small indeed.

RECOMMENDATION

Council, having attempted to handle this matter of delinquent additional dues in a just and equitable manner, requests the House of Delegates to consider the action of the Council as proper and to further clarify the 1969 House action directing the suspension of those members who have not paid the 1969 additional dues.

I would also like to express my gratitude to the members of the Headquarters office staff without whose help and assistance Council could not have functioned over the past year.

Attachment to Chairman of Council 70-1 Rejection of Himler Report

The Himler Report is impressive; it clearly recognizes the problems in delivery of health care and correctly states that organized medicine must be involved in planning reasonable solutions. However, it errs in suggesting that a state of *complete social well-being* is essential to good health. If this premise were accepted the remainder of the report might seem reasonable. But it is not reasonable. It contains misleading statements (Dr. Budd's minority report) and unrealistic proposals. One example of the latter is the suggestion that we add priorities such as birth-to-death monitoring of the physical and mental health of each indi-

vidual, with "readily retrievable" data, and that we add social and occupational counseling to our medical duties. Another proposal that seems unnecessary is that which would establish a "National Academy of the Health Professions for Research and Policy." Implementation of these suggestions alone (the Himler Report contains 20 specific detailed recommendations) would require a shift of available resources resulting in more bureaucracy but less patient care; a situation intolerable to the patient and his physician. In short, the Himler Report proposes bureaucratic solutions to complex problems, and we recommend its rejection by the Long Range Planning and Development Committee and by the House of Delegates.

Alternate proposals to this committee are the subject of separate resolutions attached.

RESOLUTION #2

Since it is both appropriate and necessary that the AMA have a firm statement as to its primary purpose and responsibility to the medical profession and to the public which it serves, therefore be it *resolved* that the AMA is to endeavor by all appropriate means to make health services of high quality available to all individuals in a dignified and acceptable manner regardless of their social class or ethnic origin, and the AMA has the duty to guide and assist the medical profession in the attainment of this objective.

RESOLUTION #3

Whereas approximately 30 million people have been added into the health care system by the inauguration of the Medicaid Program and *whereas* the increase in our population in the next ten years will add another 30 million people to be taken care of by the health care providers, therefore, be it *resolved* that the AMA appreciate the necessity of providing more health care to larger numbers of people and that the association must actively cooperate in efforts to this end, and that in the interest of attracting the most highly qualified candidates to the field of medicine that it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are minimal regimentation, a multiplicity of practiced options and freedom of choice for both physician and patient.

RESOLUTION #4

Whereas the medical profession has a monumental task ahead of it in caring for the health needs of our citizens and *whereas* to dilute these efforts by needlessly broadening this scope would be disastrous, therefore, be it *resolved* that the AMA adopt the following definition of health: Health is a state of complete physical and mental well being and *whereas* this resolution adequately covers the entire scope of health endeavor for the field of medicine and particularly the AMA, and therefore, be it *resolved* that the AMA not adopt their recommendation of the Long Range Planning Committee on Page 7, lines 1-7.

RESOLUTION #5

Whereas there has been an increasing tendency for physicians and all health personnel to leave underprivileged and rural areas over the last two decades and although the general trend of the population is also away from these same areas, the AMA recognizes

its responsibility and therefore, be it *resolved* that the AMA devote maximum effort to the provision of high quality medical care to the underprivileged and rural areas of our country.

RESOLUTION #6

Whereas the addition of 30 million people by Medicaid and the anticipated addition of another 30 million people by population growth in this decade will create serious health manpower shortages, therefore, be it *resolved* that the AMA through its Council on Health Manpower in conjunction with other professional educational associations continue to explore and develop techniques to overcome health manpower shortages.

RESOLUTION #7

Whereas the need for increasing the productivity of each physician is obvious and necessary in an effort to overcome the health manpower shortage and *whereas* the caution urged for such plans seems undeniable, therefore, be it *resolved* that: 1) An appropriate committee of the AMA immediately begin to formulate a policy on Doctor's Assistants particularly with regard to their responsibilities, limitations on their practice and the supervision of their services by qualified physicians. 2) The AMA reaffirm the principle that the basic responsibility for the care and welfare of patients lies with their physicians and that this responsibility cannot and should not be delegated. 3) The association's law division assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of doctor's assistants.

RESOLUTION #8

Whereas it has always been the goal of the AMA to render the highest quality medical care to any person, therefore, be it *resolved* that: 1) The association in seeking as its goal the highest quality of patient care in the most effective use and broadest availability of the science and art of medicine advocate factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments. 2) An appropriate committee of the AMA be charged with the task of establishing the basic criteria which any proposed system of delivery of health services or mechanisms of payment must satisfy to be acceptable. 3) The AMA endeavor to be informed of the pilot projects that are to be developed by other sources and that these sources be requested to discuss these projects with the AMA before they are put into effect. 4) The associations seek to insure that the value judgements made by these sources on plans, programs, pilot projects and payment mechanisms are firmly based on the criteria and standards that the AMA has developed for that purpose.

RESOLUTION #9

Whereas in the determination of remuneration for its members, it is the proper province of the state association rather than the AMA, be it *resolved* that: 1) The AMA urge state medical associations to undertake various studies including surveys of prevailing medical fees. 2) The AMA develop a uniform meth-

odology for conducting such studies to the end that the data from the various states and localities be comparable. 3) The AMA serve as a clearing house for the material thus obtained and after analysis make any appropriate suggestions and conclusions. 4) The AMA may urge the state medical associations to designate negotiators who are qualified to deal energetically with government agencies on all matters pertaining to tax supported programs. Such individuals or groups should be formally appointed and the government jurisdiction involved should be notified that all negotiations should be conducted through them. (Negotiators refer to the fee negotiating committee of the state medical association acting in conjunction with its legal counsel).

RESOLUTION #10

Whereas we feel that the American public will soon demand of the AMA proof of cost and quality control, therefore, be it *resolved* that the AMA urge state and county medical societies to assume the functions of utilization and peer review and we feel that the containment of the cost of health care and the appropriate quality control will thereby be effectuated.

RESOLUTION #11

Whereas all component medical societies in the AMA have formally endorsed the idea of quality health care to all, therefore, be it *resolved* that the AMA: 1) Endorse the principle of voluntary lifelong post-graduate study for all physicians and continue and accelerate the development of programs and incentives for such study. 2) Through the state medical associations it investigate the current status of in-hospital audit methods and make a similar investigation of the state of the development of this audit for office services. 3) Request that the law division clarify the extent to which a physician's responsibility for the privacy of his patient's records will permit him to cooperate in an audit of his office practice.

RESOLUTION #12

Whereas it is felt that government control of physicians would eventually end up in adversely affecting quality, therefore, be it *resolved* that the AMA obtain information from each medical society as to whether special requirements have been imposed on physicians who render services to patients under the provision of tax supported programs and obtain the specifics of what the requirements are.

RESOLUTION #13

Whereas it has become increasingly important that each hospital staff take its appropriate share of the guidance and direction of the development and course of each hospital, therefore, be it *resolved* that 1) AMA secure data from the state and county medical societies of problems of patient-hospital relationships in their areas and the measures, if any, that are being taken to solve them. 2) And on the basis of this data that the AMA identify the basic principles that apply to staff-hospital relations and encourage state and county medical societies to do the same. 3) That the AMA assist each state and county medical society in assuming its appropriate responsibility in the development of and the carrying out of guidelines and proce-

dures referring to staff and admission policies in and to the hospital.

RESOLUTION #14

Whereas the American public is apparently seeking to extend as rapidly as possible the prepayment mechanism to all facets of the health care field, therefore, be it *resolved* that 1) AMA through its current liaison with private health insurance carriers seek to obtain continuous and current information on the Medicare Program; secure data on the development of additional benefits to new fields of coverage and minimum standards of benefits and voluntary plans and that through the private health insurance carriers that it stimulate greater effort than upgrading health insurance programs. 2) That the AMA advise state and county medical societies to take similar action at their respective levels and to review their representation on the Board of Directors of the local blue plans to be sure that they are representative of individuals who are currently active in society affairs and familiar with society policy. 3) That the association seek a formal and direct channel of communication with governmental agencies with the objective of developing its own capacity for modifying existing and new programs when modifications are indicated rather than relying on private health insurance carriers for this purpose.

RESOLUTION #15

Whereas the American public continues to expect availability of health services, be it *resolved* that the AMA endorse the following principle and that is that the necessary care for all acute illnesses, somatic or mental, should be of high quality, immediately available and rendered in a suitably equipped facility and also be it resolved that the same care for chronic illnesses be rendered in a suitably equipped facility or the patient's home.

RESOLUTION #16

Whereas our society is growing increasingly more complex and difficult to move around in and *whereas* the provision of comprehensive health care becomes a more urgent factor because of this difficulty of movement. 1) Therefore, be it *resolved* that an appropriate committee of the AMA work with state health departments to gather information on availability of physicians and ancillary personnel, hospital beds, laboratories, public health nurses, social service workers and all other types of health professionals. 2) Also be it *resolved* that the AMA identify the guidelines which are necessary for rendering comprehensive health care.

RESOLUTION #17

Whereas it is impossible for state and county medical societies to fully support Public Law 89-749 as it is currently written, therefore be it *resolved* that the AMA and its component medical societies seek to evoke changes in Public Law 89-749 that would assure adequate numbers of doctors and other health professionals on the Board of Directors of the local and state comprehensive health planning agencies.

RESOLUTION #18

Whereas the AMA has served the doctor and the public well in the past and whereas no improvements

over this system in structure have been presented, therefore, be it *resolved* that the present structure of the AMA be retained and that it be strengthened by improvements and modifications in its function.

RESOLUTION #19

Whereas we feel that all the information contained on pages 52 and 53 is encompassed in the resolutions which have already been submitted by the Delegation of the Medical Association of Georgia; therefore, be it *resolved* that these four committee recommendations contained in lines 49 through 55 on page 52 and lines 1 through 23 on page 53 be rejected and be it further *resolved* that the rejection of these four recommendations necessitates the rejection of recommendation #5, page 53, lines 35 through 42.

RESOLUTION #20

Whereas the AMA has served well in the past and we of the Medical Association of Georgia feel it will continue to serve as useful purpose in the future and *whereas* we feel it can best serve in the other health professions in an organizational manner and through appropriate liaison, be it *resolved* 1) That the AMA not submerge its identity in a national Academy of Health Professions for Research and Policy. 2) That instead of the development of a National Academy of Health Professions for Research and Policy that the AMA continue to support appropriate liaison with other health professional organizations through its appropriate committees and councils.

REFERENCE COMMITTEE RECOMMENDATION
—Report of the First Vice President proposes that this House initiate an increase in the annual dues. It further recommends that the Association's governing bodies be aware of financial needs in the future and avoid if possible financial crisis situations as encountered in 1969.

Report of the Chairman of Council requests that this House endorse as proper the action of the Council during the past year in their handling of the matter of collections of the 1969 additional dues imposed by this House and that this House clarify its intent with respect to the suspension of those members of the Association who have not paid the 1969 additional dues.

The Address of the President-Elect also calls attention to the need for proper adjustments in our dues structure.

Mr. Speaker, your committee feels that all of these reports reflect thoughtful concern for our Association, its future and its potential for even greater achievement. The committee wishes to recommend approval with commendation the Report of the First Vice President and the Report of the Chairman of Council and bring to the attention of this House the benefit of some of the more important testimony received.

It is apparent that the continued successful financial picture of the Association is largely the result of inactivity on the part of those who request budget appropriations and then do not carry out the activities supported by those appropriations. This "turn-back" of appropriated funds thereby accounts for the fact that even though a large deficit was budgeted, the Association actually was able to show a slight excess of income over expenses.

Further, our Association is considered to be second only to California in the degree of activity carried on by its committees and headquarters staff, while at the same time having the lowest annual membership dues in the United States. A comparison with our neighboring states reveals the following figures: Alabama dues are \$75; Florida dues are also \$75. North Carolina dues are \$155 annually, which includes a \$60 annual building assessment for five years and \$95 annual dues. South Carolina dues are \$75 and Tennessee's are \$80. The national average state dues are \$92, with 18 states over \$100.

In summary, Mr. Speaker, the results of the testimony received by your committee indicate that all who administer programs of the Association should be urged to carry out their plans and that the Association should be prepared to finance those needed programs. Your reference committee therefore recommends that this House adopt the following resolution:

RESOLVED—That this 1970 House of Delegates approve and endorse the action of the Council of the Medical Association of Georgia in its handling of the matter of suspension of those members who have not paid the 1969 additional dues, which resulted in the retention of many members of the Association, and their corresponding support, and be it further

RESOLVED—That this House clarify its intent with respect to the handling of those members who are now suspended for non-payment of 1969 additional dues, by directing that they be removed from the membership rolls if their additional dues are not received by December 31, 1970, and be it further

RESOLVED—That this House approve an increase in the Association's annual dues to \$75 effective January 1, 1971, and urge all committees and di-



Rev. Dr. Paul B. McCleave, Director, AMA Department of Medicine and Religion.

visions of the Association to carry out their activities to the fullest within budgeted limitations, and be it further

RESOLVED—That explanations of the need for increased financing and follow-up progress reports be distributed to the county societies, keeping the membership informed on these important matters.

HOUSE OF DELEGATES ACTION—Amended the report of the Reference Committee B by deletion of the following paragraph:

"It is apparent that the continued successful financial picture of the Association is largely the result of inactivity on the part of those who request budget appropriations and then do not carry out the activities supported by those appropriations. This 'turn-back' of appropriated funds thereby accounts for the fact that even though a large deficit was budgeted, the Association actually was able to show a slight excess of income over expenses."

The House adopted without change the first two **RESOLVEDs** of the Reference Committee's resolution.

The House tabled the third **RESOLVED** until the next meeting of the house and adopted the last **RESOLVED** which directs that information be distributed to the county societies, keeping the membership informed on these important matters.

Fulton County Medical Society Councilor

FLEMING L. JOLLEY, M.D., *Atlanta*

The Fulton County delegation has been represented at all council meetings this year. The cooperative efforts of the members of your council are to be commended in their attention to the needs of providing the excellent patient care for the residents of Georgia. Our thanks to the officers of the society and each individual member of the Medical Association of Georgia staff is herewith attested.

It is anticipated that several resolutions from the Fulton County Medical Society will be introduced for the favorable consideration of the House of Delegates.

RECOMMENDATIONS

It is also recommended that the House of Delegates through Council committee appointment give consideration of an ombudsman with the continuing increase of governmental programs.

FIFTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Fulton				
William L. McDougall				
Atlanta	1,167	938	1,153	956

Allied Health Careers Committee

JOHN T. GODWIN, M.D., *Chairman*

The Chairman of the Allied Health Committee made a presentation at the County Society Officers Conference encouraging each officer to actively participate in recruiting Allied Health personnel.

A sub-committee was appointed to study the licensure of Allied Health personnel and licensure of the institutions. Due to rapidly expanding medical knowledge and responsibilities of Allied Health personnel the importance of qualified schools was stressed. No specific action was taken, but two ideas were submitted for discussion.

1. That an Allied Health Science Board, composed of all Allied Health schools be set up to establish regulations for Allied Health schools.

2. That regulations be established through the Board of Medical Examiners.

The objective would be to insure that all Allied Health schools meet the requirements of the American Medical Association.

RECOMMENDATIONS

The Committee endorsed the action of the Executive Committee recommending an additional staff person to head a new department called Continuing Education and Health Careers. This person would establish, by working with the Medical Education Committee, a program of continuing education including evaluation and records. Also in working with the Committee on Allied Health Careers, this person would head a new MAG Health Careers Program. This program would seek to:

- (a) Develop recruitment *materials* on Medicine as a career.

- (b) Conduct a statewide Medical Careers program designed to create in the minds of students a desire to seek a medical or allied medical career. (It can be proven that students recruited from rural areas tend to return to the rural areas to practice.)

- (c) Through complete information bring the prospective student into contact with the proper *educational institution*.

- (d) Compile and distribute, when necessary, information on sources of *financial assistance* for medical or allied medical education.

- (e) Supervise and encourage *placement* of medical personnel in the rural areas of Georgia by counseling with community leaders on steps to take in attracting physicians and their families.

- (f) Keep the public informed of the progress of this program and its beneficial effect on them.

- (g) Take to those rural practitioners necessary continuing education.

At the last session of the Georgia Legislature a bill was passed on the licensure of laboratories in Georgia.

Films and recruiting material continue to be distributed by the Allied Health Committee to various County Medical Societies who are working with their local community promoting Allied Health personnel recruiting.

Areawide Health Planning Committee

F. W. DOWDA, M.D., *Chairman*

Your committee on Areawide Health Planning met in regular session at the Committee Conclave and several telephone conversations have taken place since that time. It has become painfully apparent to the members of the committee that this particular program offers the greatest potential for ending some of the health problems of our country and also offers the greatest threat not only to the freedom of the physi-

cian but of the patient if it is misdirected. In order for this not to happen, it is urgent that each County Medical Society strive to attain membership on local and state boards. This alone will not do the job when you consider that each man will probably be diluted somewhere from five to 20 times and it becomes inherently necessary for the state medical societies to hire health planners to continually come up with programs ahead of the planning unit, in order that these may be properly directed and administered. If you will recall, the comprehensive health planning agencies are indeed supposed to be just planning agencies and are not supposed to be administering agents for these programs. Only in this way is the best interest of the public and medicine going to be served. This is an expensive venture but it is one that I feel we must not tarry long in undertaking.

RECOMMENDATION

I would recommend that your Medical Association of Georgia hire a comprehensive health planner to establish priorities to set goals and to write up programs for the health needs of our local counties as well as our entire state.

Medical Education Committee

J. RHODES HAVERTY, M.D., *Chairman*

Your committee on Medical Education again has been busy during this past year. It anticipates a busy year ahead.

Your committee has noted with interest and applause the increasing enrollment within our two medical schools in Georgia. One problem attendant on this increased enrollment, however, is an increasing shortage of cadavers for students in anatomy during their first year. I am pleased to report that your Medical Education Committee was able to have passed through the 1970 General Assembly a bill allowing the state Anatomical Board greater flexibility in securing bodies for dissection. This represents the first time in recent history to my knowledge that the Medical Education Committee has been called upon and has been effective in securing needed legislation for our state.

The Medical Education Committee is studying the use of externs in hospitals, and will recommend to Council certain policies regarding this matter.

Liaison has been established with the Education Committee of the Georgia Dental Association, and meetings between the two committees are planned.

The Preceptor Program, outlined and prepared by the Rural Health Committee, under the avid leadership of Dr. Thomas N. Lumsden, has been endorsed and will be supported by the Medical Education Committee.

A meeting of pre-medical advisors throughout Georgia's colleges and universities with the medical schools' Admissions officers is being planned by your committee.

It is anticipated that another of the biennial Conferences on Medical Education at Callaway Gardens will take place in February of 1971. These meetings are looked forward to by practicing physicians of our state, as well as faculty and administrative members of our two medical schools.

Your chairman notes with sorrow the retirement from active practice of Dr. Tom Godwin, a hard-

working former chairman of this committee, and the innovator of our bi-annual conference. This committee in particular, and this House, which he served as speaker so long and so well, wish him good health and many years pleasant retirement.

I have attended several national conferences on medical education and on continuing medical education, sponsored by the AMA, and AAMC, and other organizations interested in medical education. Most of the information received at these conferences has been valuable to me, and by reporting through the *Journal-MAG* and to other members of the committee, hopefully to the Association as a whole. This committee is an extraordinarily important committee to the Association, and its involvement in formal medical education, postgraduate education including internship and residency training, and continuing education for physicians is a function that must be continued.

I have enjoyed the chairmanship of this committee for three years now, and feel that other interests should have an opportunity to direct its future involvement. Consequently, although I would welcome the opportunity to continue to serve on the committee, I am resigning as its chairman.

I would like to conclude this yearly report with a recommendation.

RECOMMENDATION

Last year I recommended that the MAG staff be increased by one field service person, preferably a physician, to initiate, coordinate, and carry out programs in continuing medical education for the physicians of Georgia.

This year I reiterate this recommendation, this time with the backing of the entire Medical Education Committee, and of the Executive Committee of Council. My present recommendation is that a field service person be added to the staff whose prime function to the Association would be in the area of continuing education in the health fields. His responsibilities would include concern for the improvement of medical and allied health personnel, and encouragement in continuing education for these individuals. More specifically, it would be his responsibility to plan and staff such continuing education programs, working closely with our two medical schools, our several schools of Allied Health Professions, the Georgia Regional Medical Program, the Comprehensive Health Planning programs, and all other interested parties.

Supplemental Report of Council

C. E. BOHLER, M.D., *Chairman*

At its meeting on May 6, 1970, Council considered the matter of employing a Health Planner as an additional member of the MAG Staff.

In considering this matter the Council was aware of the various additions to the staff recommended in various other reports that have been filed with the House of Delegates. Specifically these reports recommend the employment of a lay coordinator for peer review, an ombudsman for health programs, a comprehensive health planner and an additional field service representative.

The Council overview of the entire concept of additional staff is that the employment of a Health Planner should assume first priority and such position would in

fact assume many of the responsibilities of the various positions contemplated by the hiring of other staff personnel.

RECOMMENDATION

On the basis of Council consideration of the above matter, it is recommended that MAG employ a Health Planner whose function will include obtaining grants, gifts, etc. from governmental, foundation, and other sources with which to finance Association-approved health programs. And further, it is recommended that the continued employment of this individual beyond the first year will be contingent upon his ability to attract funds sufficient to offset his salary and that of his staff.

REFERENCE COMMITTEE RECOMMENDATION
—Report of the Councilor for Fulton County Medical Society (Jolley) recommends an additional staff person called an ombudsman; Allied Health Careers recommends an additional staff member for continuing education and health careers; Areawide Health Planning recommends an additional staff person for health planning; Medical Education recommends an additional field representative for continuing education and Supplemental Report, Council, recommends the employment of a health planner.

Mr. Speaker, your reference committee attempted to assess the possible overlap of the intent of these staff recommendations and believes that this intent is best summarized in the recommendation of the Council. However, while fully recognizing the desirability of hiring an individual who can guarantee to attract programs, grants, etc., which will result in income to the Association to offset his salary and that of his staff, the Reference Committee is of the opinion that it was not the intent of Council to be as rigid as the recommendation sounds and that the *potential* results of the employee will be taken into consideration in his future employment. Your reference committee therefore recommends that these reports be *approved with commendation, except for the recommendations contained in them*. Your reference committee further recommends that the recommendation of the Supplemental Report of Council be *approved with amendment* by the insertion of the word "potentially" in the last sentence of the recommendation, so that the sentence would read:

"And further, it is recommended that the continued employment of the individual beyond the first year will be contingent upon his ability to potentially attract funds sufficient to offset his salary and that of his staff."

HOUSE OF DELEGATES ACTION—Adopted the Reports as recommended by the Reference Committee.

President-Elect's Address

F. G. ELDRIDGE, M.D., *Valdosta*

(See proceedings of the First General Session)

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee wishes to call attention of all Delegates to the excellent address of the President-Elect and to the recommendations contained therein, which reflect proposed goals for the coming year. Recognizing that the intent of the fifth recommendation in the President-Elect's Address has been

accounted for through a previous recommendation of your Reference Committee, we recommend approval with commendation of the President-Elect's Address.

HOUSE OF DELEGATES ACTION—Adopted the President-Elect's Address and its recommendations as recommended by the Reference Committee.

Resolution 70-20

Committee to Study Malpractice Suit Problem

MILFORD B. HATCHER, M.D.

WHEREAS, there has been an increase in the number of malpractice suits and from all indications there will be a further increase in the years to come; and

WHEREAS, whether justified or not, it imposes a financial as well as mental burden upon the practicing physician; and

WHEREAS, apparently the only recourse available now is through the legal profession and the courts, and at times the notification of the law suit having been filed is the first knowledge that the physician may have concerning the allegation of malpractice; and

WHEREAS, there should be other methods whereby the physician and the legal representative could work out a just settlement, if such a method or plan were available; therefore

BE IT RESOLVED, that the Council of the Medical Association of Georgia appoint a special committee to study this problem and ask that they confer with representatives of the legal profession and the insurance carriers and other parties they feel could benefit this committee. They may explore plans of other state, national, or governmental agencies in working out a satisfactory plan and report back to the Council of the Medical Association of Georgia their recommendations.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee fully recognized the intent of this resolution and the problem areas which precipitated it, as encompassed in the "Whereas" portions of the resolution. It was also pointed out to the committee in the testimony of many that our existing Committee on Insurance and Economics has spent many hours in supervision of MAG's Group Malpractice Insurance Plan, which has resulted in Georgia's having premium rates among the lowest in the nation. In order to capture the intent of Resolution 70-20 and at the same time be sure that our most knowledgeable individuals continue to work on the problem of malpractice insurance in Georgia, your reference committee recommends approval of this resolution with amendment as follows:

In the last RESOLVED, strike the words "appoint a special," and insert in lieu thereof the words, "urge the present," and further strike the word "to" and insert in lieu thereof the words "Insurance and Economics to continue to," so that the first sentence would then read:

"Resolved, that the Council of the Medical Association of Georgia urge the present Committee on Insurance and Economics to continue to study the problem and ask that they confer with representatives of the legal profession and the insurance carriers and other parties they feel could benefit this Committee."

HOUSE OF DELEGATES ACTIONS—Adopted Resolution 70-20 with the changes as recommended by the Reference Committee.

Chairman Bates then reported that this concluded the report of the Reference Committee B and thanked the members of his Committee and Mr. Smith for their work on the preparation of the report. Chairman Bates then moved that the Reference Committee report be adopted as a whole. This motion was duly seconded and approved.

Report of Reference Committee C

Virgle W. McEver, Jr., M.D., Chairman

Chairman McEver reported that reports and resolutions referred to Reference Committee C were considered by the Committee which met at 9:00 a.m., in the Lounge, Carriage Inn, Jekyll Island, on May 9, 1970. Members of the Committee present included: Virgle W. McEver, Jr., M.D., Warner Robins, Chairman; Clyde A. Burgamy, M.D., Augusta, Vice Chairman; Jack Hirsch, M.D., Columbus; Charles E. Todd, M.D., Atlanta; and C. Roy Williams, M.D., Wadley.

Alternate-Delegate to AMA

F. W. DOWDA, M.D.

Your Alternate AMA Delegate has very proudly during the past year taken part in the election of Dr. J. Frank Walker to Vice Speaker of the House of Delegates. I think this is an accomplishment which all of us in your AMA Delegation take with a great deal of pride; however, I do think it is worthwhile pointing out to you all that the excellent reputation of the Medical Association of Georgia aided us a great deal in the election of Frank to this high office and I think each one of you can take pride in having such an organization and participating in it and being a guiding force in it.

RECOMMENDATIONS

After several years of observation of the AMA House of Delegates, it seems to me that it holds many good features which we of the Medical Association of Georgia should seek to emulate. One of these is the representation of specialty societies by delegate. The second is the representation of the Student American Medical Association by delegate and I would recommend to this House of Delegates that both of these steps be taken.

REFERENCE COMMITTEE RECOMMENDATION

—Your reference committee recommends approval of this report by deleting the first sentence of the Recommendations and substituting in lieu of the remainder of the Recommendations the following:

(1) That one Delegate representative from each of the specialty societies now represented on the MAG Medical Review and Negotiating Committee be elected annually by said specialty societies to be a member of the MAG House of Delegates.

(2) That one ex-officio Non-Voting Delegate to the House of Delegates be elected annually by each SAMA Chapter in Georgia.

Your reference committee further recommends that upon approval of these two recommendations, the MAG Constitution and Bylaws Committee be in-

structed to draw appropriately worded amendments to be presented to the House of Delegates at the 1971 session.

With respect to the first amendment to this report (relating to specialty society representation), your Reference Committee is of the opinion that this would be an appropriate step in involving a greater number of physicians in the decision-making process and to this end would lend structural strength to the Association.

With respect to recommendation number 2 (related to SAMA representation), your Committee feels that ex-officio status would be a more appropriate beginning than full-fledged Delegate membership, and that the matter can be evaluated at a later date to determine the advisability of further amendments.

HOUSE OF DELEGATES ACTION—Rejected Recommendation (1) of the Reference Committee relating to Delegates representing specialty societies and adopted recommendation (2) of the Reference Committee as recommended by the Reference Committee.

Constitution and Bylaws Committee

GEORGE H. ALEXANDER, M.D., *Chairman*

The Constitution and Bylaws Committee has held two meetings, the first being at the Committee Conclave on July 26, 1969, and the second at the headquarters office on November 16, 1969.

The following two paragraphs are quoted from the Chairman's Preliminary Report to Council September 20, 1969:

"Preliminary consideration was given to several matters which had been referred to the Committee. These matters, some of which may have to be referred to the House of Delegates in the form of proposed amendments, were discussed with Legal Counsel, Mr. John Moore, by the Chairman and Mr. Moffett in conference on August 29. Mr. Moore was requested to prepare preliminary language for amendments as indicated for consideration by the Committee at a later meeting.

"The most important matter discussed with Mr. Moore at the August 29 conference was the manner of the adoption of the new method for the election of officers by the House of Delegates at the Annual Session in May at Savannah. Mr. Moore has prepared an official opinion concerning the legality of this action. This is a most logical document and I, as Chairman, am happy to concur in the opinion and to endorse it. In order to go further in removing any question concerning this matter, I feel that it would be well for Council to also concur in and endorse the opinion of our Legal Counsel. Copies of Counsel's opinion will be available for your information."

A copy of Mr. Moore's official opinion is attached, hereto, for the study and action, if needed, by the House of Delegates. This opinion was endorsed officially by Council at its meeting in September 1969 and the following is quoted from Council Minutes:

"CONSTITUTION AND BYLAWS COMMITTEE REPORT—At the request of the Chairman, Dr. George H. Alexander, Mr. Moffett presented this report in Dr. Alexander's absence. At an August 29 meeting with Mr. John Moore, the manner of the adoption of the new method for the election of officers by the House of Delegates as approved in May 1969

at the Annual Session, was discussed. Mr. Moore was asked to prepare an official opinion concerning the legality of this action. Copies of this opinion will be made available to the Reference Committee and to the House of Delegates if desired. It is the opinion of legal counsel that the provisions of Chapter V of the Bylaws governing the election of officers of the Association by the House of Delegates as contained in the present edition of the Bylaws of the Medical Association of Georgia are valid and properly adopted. On motion (Rogers-Dowda) Council agreed that the procedure established at the 1969 House of Delegates was properly adopted."

At the second committee meeting on September 16, the Committee also endorsed the validity of the new election procedure as brought out in Mr. Moore's opinion.

The Committee at its second meeting discussed several minor amendments to the Bylaws and approved necessary language for presentation of these amendments for your consideration. These items are being presented as follows, with comment upon some and the committee recommendation wherever such was made:

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BYLAWS OF THE MEDICAL ASSOCIATION OF GEORGIA

Resolved that the Constitution and Bylaws of the Medical Association of Georgia be amended in the following particulars:

NOTE: (The present language of the Constitution and Bylaws is stated first and is headed "Present Bylaws." This is then followed below by the proposed amendment(s) to the appropriate Chapter and Section headed "Proposed Bylaws Amendment.")

Present Bylaws

Chapter I, Section 4

SECTION 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and are eligible to vote and hold office in the society shall be Active Members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office and vote and receipt of the *Journal of the Medical Association of Georgia*, and these members shall pay full dues to the Association annually. New members entering practice after July 1 may pay one-half the annual dues. Active members may be excused from the payment of Association dues for the duration of one of the following circumstances: (1) financial hardship or illness; (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital; (3) being retired from Active practice, or (4) service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned Medical Officer in the Reserve Armed Forces. Relief from payment of dues shall not become effective until a lapse of 90 days, at which time it will become retroactive and extend through the applicable period. Dues exemption of active members when granted shall be upon recommendation of the member's constituent local society.

Proposed Bylaws Amendment

Amend Chapter 1, Section 4 of the Bylaws, by striking subsection (3) thereof in its entirety and by renumbering subsection (4) thereof subsection (3) and by striking the last sentence of new subsection (3) thereof reading "Dues exemption of active members when granted shall be upon recommendation of the member's constituent local society.," and by inserting in lieu thereof a new final sentence to read as follows:

"Dues exemption of active members shall be granted or denied by the Council of the Association after recommendation of the member's constituent local society, and the Council shall be fully empowered to grant or deny such dues exemption of active members even if the member's constituent local society had recommended such exemption."

And, further amend Chapter I, Section 4 of the Bylaws by adding a paragraph at the end of said Section 4 to read as follows:

"Those active dues exempt members exempt from payment of Association dues because of financial hardship and illness shall continue to receive the *Journal of the Medical Association of Georgia* without cost. The other categories of active dues exempt members shall not receive any publication of the Association except by personal subscription."

so that said Chapter I, Section 4 of the Bylaws then reads as follows:

"SECTION 4. ACTIVE MEMBERS. Physicians who are members in a component county medical society and who are eligible to vote and hold office in the society shall be Active Members, unless otherwise classified by action of the component county society. These members shall have full privileges of Association membership including the right to hold office, vote and receive the *Journal of the Medical Association of Georgia*, and these members shall pay full dues to the Association annually. New members entering practice after July 1st may pay one-half the annual dues. Active members may be excused from the payment of Association dues for the duration of one of the following circumstances: (1) financial hardship or illness; (2) postgraduate training, defined as that period during which a member participates in an organized training course within a hospital; or (3) service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned Medical Officer in the Reserve Armed Forces. Relief from payment of dues shall not become effective until a lapse of 90 days, at which time it will become retroactive and extend through the applicable period. Dues exemption of active members shall be granted or denied by the Council of the Association after recommendation of the member's constituent local society and the Council shall be fully empowered to grant or deny such dues exemption of active members even if the member's constituent local society had recommended such exemption.

Those active dues exempt members exempt from payment of Association dues because of financial hardship and illness shall continue to receive the

Journal of the Medical Association of Georgia without cost. The other categories of active dues exempt members shall not receive any publication of the Association except by personal subscription."

COMMITTEE RECOMMENDATION: For Adoption

COUNCIL ACTION: Recommends Adoption

Present Bylaws

Chapter I, Section 5

SECTION 5. SERVICE MEMBERS. Physicians eligible for Service Membership are full-time commissioned Medical Officers of the Government in the U.S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration and Indian Service, and those physicians who have retired from the Services by federal law. Service members need not be licensed to practice medicine in the state of Georgia provided they are physicians holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association. Such members shall not be required to pay the annual dues and they shall not be entitled to vote or hold office; nor shall they receive any publications of the Association except by personal subscription.

Proposed Bylaws Amendment

Amend Chapter I, Section 5 of the Bylaws by adding the words "and who are retired from gainful employment." to the end of the first sentence of said Section 5 so that said first sentence reads as follows:

SECTION 5. SERVICE MEMBERS. Physicians eligible for Service Membership are full-time commissioned Medical Officers of the Government in the U.S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration and Indian Service, and those physicians who have retired from the Services by federal law and who are retired from gainful employment.

Present Bylaws

Chapter I, Section 7

SECTION 7. AFFILIATE MEMBERS. Persons in the following classes may become affiliate members:

a. American Physicians, located in foreign countries or possessions of the United States, and engaged in medical missionary and similar educational and philanthropic labors;

b. Dentists, who hold the degree of D.D.S., or D.M.D., who are members of their state and local dental societies;

c. Pharmacists who are active members of the Georgia Pharmaceutical Association;

d. Veterinarians who hold the degree of D.V.M. and are members of the Georgia Veterinary Association;

e. Teachers of medicine, or of the sciences allied to medicine who are not eligible for membership;

f. Scientists in sciences allied to medicine and who are not eligible for membership.

Proposed Bylaws Amendment

Amend Chapter I, Section 7 of the Bylaws by

striking present subsections e and f and inserting in lieu thereof a new subsection e and subsection f to read as follows:

"e. Teachers of medicine who are not eligible for active membership;

"f. Teachers of, or scientists in, sciences allied to medicine and who are not eligible for active membership."

Present Bylaws

Chapter I, Section 9

SECTION 9. LIFE MEMBERS. A member in good standing who is 70 years of age may be classified as a Life Member and excused from the payment of Association dues and assessments upon his application to the Association through his component county society as follows: his application shall be granted in due course if such member has been continuously an active dues-paying member of this Association for 25 years; his application shall be granted in due course if he has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years provided he has been an active dues-paying member of this Association for at least 10 years of those 25 years; his application may be granted upon action of Council if he has been an active dues-paying member of this Association and any other constituent association or associations of the American Medical Association continuously for 25 years but has been an active dues-paying member of this Association for less than 10 years. Service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned medical officer in the Reserve Armed Forces shall count as part of the period of continuous years of dues-paying membership. Life Members excused from the payment of Association dues shall have the right to vote and hold office but shall not receive any publications of the Association except by personal subscription.

Proposed Bylaws Amendment

Amend Chapter I, Section 9 of the Bylaws by deleting the last 13 words of said Section 9 and inserting in lieu thereof the following:

"... and shall continue to receive the *Journal of the Medical Association of Georgia* without cost."

so that the last sentence of Section 9, Chapter I then reads as follows:

"Life Members excused from payment of Association dues shall have the right to vote and hold office and shall continue to receive the *Journal of the Medical Association of Georgia* without cost."

Present Bylaws

Chapter IX, Section 1

SECTION 1. STANDING COMMITTEES. The standing committees of the Association shall be as follows:

- (A) Executive Committee of Council
- (B) Committee on Finance

- (C) Committee on Professional Conduct
- (D) Committee on Woman's Auxiliary
- (E) Committee on Constitution and Bylaws
- (F) Committee on Annual Session
- (G) Committee on Traffic Safety

Proposed Bylaws Amendment

Amend Chapter IX, Section 1 of the Bylaws by striking subsection (G) and by inserting in lieu thereof a new subsection (G) to read as follows:

"(G) Committee on Emergency Medical Services"

Present Bylaws

Chapter XIII, Section 2

SECTION 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and Bylaws.

Proposed Bylaws Amendment

"Amend Section 2 of Chapter XIII of the Bylaws by striking said Section 2 in its entirety and by inserting in lieu thereof a new Section 2 to read as follows:

"SECTION 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Sturgis, "Rules of Parliamentary Procedure," unless contrary to this Constitution and Bylaws."

COMMITTEE RECOMMENDATION

The Committee called upon Dr. Harrison Rogers, the Speaker of the House of Delegates, for some illumination for the committee's benefit concerning "Sturgis Rules of Parliamentary Procedure." This matter was discussed at length with Dr. Rogers. The Committee did not feel that it had adequate information or was knowledgeable enough at this point to make a recommendation either way. It was, therefore, voted that this be referred to the House of Delegates where it could be fully discussed before a Reference Committee and on the floor of the House with discussion pro and con. The Committee, therefore, recommended procedure for consideration and action for or against by the House of Delegates, but the Committee makes no recommendation for or against.

The Committee was asked by the House of Delegates to prepare necessary amendments to make the Presidents of the Student American Medical Association Chapters of the Medical College of Georgia and of the Emory University School of Medicine ex-officio members of Council without the right to vote. If it is the wish of the House of Delegates that this be done, it will be necessary for an amendment to the Constitution to be made as Article VI, Chapter I, definitely states what the makeup of Council shall be. I quote from the minutes of the Committee Meeting at the Committee Conclave in July, 1969, as follows:

"SAMA PRESIDENTS AS EX-OFFICIO MEMBERS OF COUNCIL—Pursuant to an action by the House of Delegates the Committee was to investigate and recommend to Council whether or not SAMA Chapter Presidents in Georgia should be named in the Constitution as ex-officio members of MAG Council.

During the discussion of this matter it was pointed out that ex-officio status would confer upon non-dues paying (and possibly non-members) persons certain rights not accorded individual members of the Association. Following lengthy discussion the Committee agreed to recommend to Council that the Georgia Chapter SAMA Presidents continue to be invited to attend Council meetings as guests but that ex-officio membership on the Council not be recommended to the House of Delegates in the form of an amendment to the Constitution."

Attention is called to the two amendments to the Constitution which were introduced last year and have been lying on the table for your action at this (1970) meeting.

The following provides a narrative account of the action of the 1969 Reference Committee on these two Constitutional amendments:

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee acknowledges receipt of a proposed amendment to Article VII, Section 3 of the Constitution. This amendment would change the criterion for calling a special meeting of the Association or the House of Delegates.

Presently the Constitution provides that special meetings may be called on written petition of 20 delegates to the House of Delegates. This amendment would increase this to one-third of the membership of the House of Delegates. At its present level of 165 delegates, this would mean that it would require 55 delegates to call a special meeting of the House or the Association.

Because this is a constitutional amendment it cannot be voted on at this session of the House, but must lay on the table for a year to be voted on at the 1970 session.

Another constitutional amendment not included in the written report of the Constitution and Bylaws Committee, but approved by Council in meeting May 3, 1969, was received and will be placed on the table for consideration in 1970. This amendment which provides for the election (not nomination) of councilors and vice-councilors by their respective constituent societies is as follows:

Strike Section 2 of Article IX of the Constitution and Bylaws in its entirety and insert in lieu thereof the following:

ARTICLE IX, Section 2. Election and Eligibility. The Officers of the Association, with the exception of the councilors and vice-councilors, shall be elected during the Annual Session as provided for in the Bylaws. Councilors and vice-councilors shall be elected as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

Acknowledgement is made with appreciation to our Legal Counsel, Mr. John L. Moore, Jr., of Alston, Miller and Gaines, and to Mr. Jim Moffett of staff for their able assistance in the work of this Committee.

Constitution and Bylaws Committee

Supplemental Report 70-1

GEORGE H. ALEXANDER, M.D., *Chairman*

It has been called to the attention of the Committee

that since the Association is changing over to the fiscal year from June 1 to May 31 that committee appointments for the year are being made during the month of May. Because of the fact that these appointments are being made during May, it is the feeling of some of the officers that a meeting of Council will not necessarily be required in June and the Committee has been requested to prepare an amendment to the Bylaws which would make the time of Council meetings more flexible.

The following is being presented for your consideration:

RESOLVED that Section 4, Meetings, of Chapter IV of the Bylaws be amended by striking the first sentence of said Section 4 which reads—"The Council shall meet at the close of the Annual Session to organize and at intervals of not more than four months until the next Annual Session." Be it further resolved that in place of the deleted sentence the following sentence be adopted: "The Council shall meet at the close of the Annual Session to organize. Between the organizational meeting of Council and the following Annual Session, Council shall meet a minimum of three times, the time and place of such meetings to be determined by Council." Be it further resolved that Section 4 of Chapter IV be amended as follows:

"(1) Amend the next to the last sentence of said Section 4 by striking the word 'three' (which is the fourth word from the end of the sentence) and inserting in lieu thereof the word 'eight,' and

"(2) Amend said Section 4 by deleting the last sentence thereof."

COMMENT: The reason for changing the number of members of Council required to call a special meeting of the Council is the following:

The provision for three members to call a special meeting of Council dates back to the period when Council was composed of 10 district councilors and the officers, the number at that time being approximately 20 per cent of the membership. Eight members would be approximately 20 per cent of the present membership of the Council.

Constitution and Bylaws Committee

Supplemental Report 70-2

GEORGE H. ALEXANDER, M.D., *Chairman*

Since the Constitution and Bylaws was last amended the title of Executive Secretary and the Associate Executive Secretary have been changed to Executive Director and Associate Director.

Throughout the Constitution and Bylaws the positions are referred to as Executive Secretary and Assistant Executive Secretary. In the Constitution these titles are used two times and in the Bylaws they are used 13 times. In order to make the Constitution and Bylaws technically accurate it is recommended that the following be adopted by the House of Delegates:

RESOLVED, that Article V, Section 1 and Article VI, Section 1 of the Constitution be amended by deleting the words Executive Secretary wherever they appear and substitute the words Executive Director.

Inasmuch as this change would constitute amendments to the Constitution, this amendment would have to lay on the table for a year before the House could vote to effect this change.

BE IT FURTHER RESOLVED, that the Bylaws be amended generally throughout by deleting the words Executive Secretary and inserting in lieu thereof the words Executive Director, and by deleting the words Assistant Executive Secretary and inserting in lieu thereof the words Associate Director.

REFERENCE COMMITTEE RECOMMENDATION
—The report of the Committee on Constitution and Bylaws, Supplemental Report 70-1 and Supplemental Report 70-2 of the Committee were treated together as each of these reports deal only with proposed amendments to the Constitution and Bylaws.

Two Constitutional amendments received by the House of Delegates in 1969, to lay on the table for a year, are now the proper concern of the House and may be voted upon.

The first of these two amendments would amend Article VII, Section 3 by changing the criterion for calling a special meeting of the Association or of the House of Delegates. The present Constitutional requirement for this purpose is the written petition of 20 Delegates; two-thirds of the members of Council or one-fourth of the membership of the Association.

The precise language of the Constitutional amendment at issue here is as follows:

ARTICLE VII, Section 3. Special Meetings: Special meetings of either the Association or of the House of Delegates may be called by a two-thirds vote of the Council, upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.

Your Reference Committee shares the view expressed by the Committee on Constitution and Bylaws that the right to call a special meeting should not be lodged with so small a group as 20 delegates to the House of Delegates and accordingly recommends adoption of this amendment to the Constitution.

The second Constitutional amendment provides for the election, rather than merely the nomination, of Councilors and Vice Councilors by their respective constituent Societies. This amendment would then bring the Constitution in line with the Bylaws as a similar provision in the Bylaws was adopted previously.

The precise language of the Constitutional amendment at issue here is:

ARTICLE IX, Section 2. Election and Eligibility. The Officers of the Association, with the exception of the Councilors and Vice Councilors, shall be elected during the Annual Session as provided for in the Bylaws. Councilors and Vice Councilors shall be elected as provided for in the Bylaws. No member shall serve as an officer who has not been a member of the Association for the preceding three years.

In view of the fact that the House expressed its intent to have Councilors and Vice Councilors elected by their respective Societies when this provision was written into the Bylaws, your Reference Committee recommends adoption of this Constitutional amendment to make the Bylaws and the Constitution consistent on this point. It should be pointed out that this amendment would not disturb the Bylaws provision for the election of Councilors and Vice Councilors in the event the constituent societies fail to do so.

Chapter I, Section 4: This proposed amendment would accomplish two objectives, both of which are viewed to be desirable by the MAG Council. First, it would provide that the Council shall have the right to grant or deny dues exempt status to MAG members rather than grant dues exempt status automatically on petition from the affected member's County Medical Society. Your Reference Committee feels this is a wise and orderly procedure as it will serve to abate any misunderstanding at the local level as well as eliminate the potential for abuse.

Secondly, this amendment would provide that in cases of dues exempt status for financial hardship or illness that the member would continue to receive the *Journal of the Medical Association of Georgia* without charge. Again your Reference Committee concurs in this provision on the grounds that it is just and equitable.

Chapter I, Section 5. SERVICE MEMBERS. The present Bylaws (Chapter I, Section 5) provide that Service Members be excused from the payment of dues irrespective of whether or not they are gainfully employed. The proposed amendment would make an exception of those Service Members who remain active in some work capacity.

It was the feeling of the Committee that an assumption was made that when a physician retires from Service that his days as a practitioner were concluded. In many cases this is true and when such occurs Service membership would be available without the payment of dues. However, it is also recognized that retirement from Service does not necessarily mean retirement from the practice of medicine (including administration) and therefore your Reference Committee feels that excuse from the payment of dues should not be granted to Service members except in cases where the subject physician is no longer gainfully employed.

Your Reference Committee recommends adoption of this amendment.

Chapter 1, Section 7. Amendments to subsections (e) and (f) of Section 7, Chapter 1 are technical only and designed to encourage Active membership on the part of those eligible.

Chapter 1, Section 9. This amendment proposes only that Life Members, a classification of membership created by the 1969 House of Delegates, be permitted to receive the *Journal of the Medical Association of Georgia* without cost.

On the basis that Life Membership is not available until one reaches his 70th birthday, your Reference Committee concurs with the amendment and recommends its adoption.

Chapter IX, Section 1. The amendment proposed to this Chapter and Section changes the name of the Standing Committee on Traffic Safety to the Committee on Emergency Medical Services.

This change of name was directed by the House of Delegates in 1969. Your Reference Committee recommends adoption of this amendment.

Chapter XIII, Section 2. The present Bylaws provide that the conduct of business in the House of Delegates will be governed by "Robert's Rules of Order, Revised" unless contrary to the MAG Constitution and Bylaws.

The proposed amendment to Chapter XIII, Section 2, would substitute "Sturgis Standard Code of Parliamentary Procedure" for "Robert's Rules of Order."

Your Reference Committee feels that parliamentary procedure as enunciated by Sturgis is a more orderly procedure, less cumbersome and therefore better suited to MAG purposes and accordingly recommends adoption of this proposed amendment.

SAMA PRESIDENTS AS EX-OFFICIO MEMBERS OF COUNCIL—The Committee on Constitution and Bylaws considered the question of SAMA Presidents from the two Georgia medical schools being given a position on the MAG Council. The Constitution and Bylaws Committee recommends against this addition to the Council for what seems to your Reference Committee to be good and sufficient reason. Specifically, membership on the Council would grant to SAMA members (not necessarily MAG members) a direct voice, a direct vote and the vantage point from which to be influential, while at the same time it is recognized that this same privilege is not available to all dues paying MAG members.

Almost everyone agrees that communications with SAMA is desirable, and to this end your Reference Committee would recommend a continuation of Council's present policy of inviting the Presidents of the two Georgia SAMA Chapters to all meetings of Council.

SUPPLEMENTAL REPORT 70-1—CONSTITUTION AND BYLAWS—Supplemental Report 70-1 of the Committee on Constitution and Bylaws proposes amendments to Chapter IV, Section 4 of the Bylaws to accomplish two objectives. First, it gives a degree of flexibility as to the prescribed meeting dates of the Council by removing the requirement that Council must meet at intervals of not more than four months and provides instead that Council shall meet a minimum of three times a year plus a fourth meeting held at the close of the Annual Session for organizational purposes. Your reference committee agrees that changing the Association's accounting period from a calendar year to a fiscal year (June 1-May 31) makes it both possible and desirable that flexibility as to meeting dates of the Council be written into the bylaws and accordingly it is recommended that this change be adopted.

The second change recommended by the Committee on Constitution and Bylaws to Chapter IV, Section 4 relates to the number of members of Council required to call a special meeting of the Council. Specifically, the recommended change increases from three members to eight members the number required to call special meetings. The reason advanced in the Supplemental Report is that the increase in the size of Council should be accompanied by a correspondingly proportionate increase in the number required to call a special meeting. Your Reference Committee concurs in this and recommends adoption of this amendment.

SUPPLEMENTAL REPORT 70-2—CONSTITUTION AND BYLAWS—This report calls only for technical improvements in the Constitution and Bylaws to correct the titles by which the Executive Director and the Associate Director are referred.

Your Reference Committee recommends adoption with commendation of these reports.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

Legislation Committee (National)

J. FRANK WALKER, M.D., *Chairman*

On the national legislative level three matters tend to dominate the interest of the medical profession during the early months of the second session of the 91st Congress. These are: The large number of bills introduced to include chiropractic in the Title XVIII, Medicare program; National Health Insurance, including the AMA Tax Credit alternative; and a Senate Finance Committee Staff report on "Medicare and Medicaid—Problems, Issues and Alternatives."

CHIROPRACTIC—Approximately 90 bills have been introduced for the purposing of legislating chiropractors, as providers of service, into the Medicare program. One of these bills has been offered by Congressman W. S. (Billy) Stuckey of Georgia's Eighth Congressional District. It is too early to tell just how serious any given Congressman, or the Congress as a whole, might be regarding actual enactment of such legislation. It is known, for instance, that many of these bills were introduced "at request" which simply means that they were introduced to please some constituents with no real intention of pursuing them to the point of enactment. Your Committee on National Legislation will actively oppose these bills.

NATIONAL HEALTH INSURANCE—During recent months proposals and announcements of intentions to announce proposals concerning national health insurance have been forthcoming from numerous sources. As of the time of the writing of this report seven such plans have been revealed or partially revealed. Below is a comparison of these plans including the one advocated by the AMA.

The AMA "Medicredit" plan is based on a system of federal income tax incentives through which individual and family taxpayers would be encouraged to obtain adequate health insurance protection. The amount of tax credit granted an individual or family would be in proportion to the amount paid in federal income taxes. Those in low income groups with little or no tax liability would, under the AMA's proposal, receive "medical care vouchers" which could be used to purchase qualified health coverage from private insurance companies or prepayment plans.

Other proposals in this summary include measures offered by Congressman Richard Fulton and Senator Paul Fannin, Congressman Durward Hall (M.D.), Walter Reuther's Committee of 100, Rockefeller-Javits, Senator Edward Kennedy and the AFL-CIO.



Reference Committee D considers the reports and resolutions referred for their recommendations.

A COMPARISON OF NATIONAL HEALTH INSURANCE PLANS

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
American Medical Association "Medi-credit"	To encourage all persons to be protected against expense of illness. Uses private inservice carriers stating that competitive system provides incentives for lowering costs, innovations in delivery of care, and maintenance of quality.	Taxpayer may purchase "qualified" insurance policy and takes credit (based on his tax liability) on tax return for part of premium cost; or, if in lower 30% income group, receives certificate good for full cost of premium.	Income tax <i>credit</i> ranging 10% of premium cost to 100% depending on family tax liability; lower 30% of taxpayers to receive certificate covering 100% premium cost.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Federal financing through tax credits and "certificates"; state approval of insurance company and plan; an independent Health Insurance Advisory Board sets guidelines.	All persons under 65, except military. Elderly's cost of Part B Medicare plan also included.	Basic: All M.D. and osteopathic services plus 60 days hospital; Supplemental: drugs, other personal health services. For over 65 person: the Part B Medicare program.	Estimated \$10.2 billion total, less savings of Federal share of Title 19 (\$2.6 billion); Net federal cost \$7.6 billion.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
Tax Credit Bills of Fulton (HR9835) and Fannin (S2705)	To make it possible for every citizen to obtain comprehensive medical and hospitalization insurance of his choice on guaranteed renewable basis.	Provides for voluntary health insurance coverage for all persons, with the federal government's financial participation based on the taxpayer's income. Taxpayer takes credit on his tax return or receives insurance premium certificate.	Income tax <i>credits</i> based on taxpayer's adjusted gross income, credit ranging from 25% (over \$7,500 income) to 100% (under \$2,500 income). Maximum federal contribution \$400 per family.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Federal financing through tax credits and insurance premium certificates. State approval of insurance company and plan.	All persons.	As may be offered by individual insurance company; also, for over 65 persons, the Part B Medicare program.	Not stated.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
Congressman Durward Hall*	To provide a two part program; first, to do away with Medicaid; second (at later date), to provide protection against catastrophic illness.	Part I: Federal government to pay cost of health insurance policy for "Medicaid" individual. Part II: Establishes a federal pool of general revenue funds to cover "catastrophic" illness of all persons.	Part I: Federal, through payment of cost of insurance certificate; Part II: From federal general revenues.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Federal: financing and setting of policy minimum benefits. State: approves insurance carriers, including Blues.	Part I: Title 19 recipient. Part II: All others when faced with catastrophic illness.	Part I: Basic coverage as defined by Congress (about 85% of health care expenses); Part II: Catastrophic health care expenses.	Part I: \$3.5 billion. Part II: not stated.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
"Committee of 100"—Walter Reuther*	To provide a national health insurance plan which would restructure the delivery system and pay for all personal health care, including hospital, medical, and dental.	Administered by HEW, with Advisory Council including representatives of consumers and providers; would absorb Medicare, Medicaid, and many other collateral programs.	Contributions from employers, employees, and self-employed, and from general tax revenues; also provision to permit employer to assume employee's payment. Estimated: two-thirds, employer-employee; one-third, federal.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Sets up broad federal involvement in the whole structure of health care delivery; provides for federal standards for care and federal licensure of providers.	All persons.	All diagnostic, medical and surgical care; hospitalization; dental; nursing home; home health services; drugs, appliances, hearing aids, eye-glasses; other health services.	Estimated at \$40 billion, annually.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
Rockefeller-Javits*	To provide for a compulsory system of insurance against the costs of basic health services.	Establishes a Health Benefits Commission to implement program; requires employers to maintain insurance or other program covering health needs of employees; covers unemployed through "pool" funds.	Employer-employee contributions; for indigent; from federal, state and local contributions to pool.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Part federal financing; federal appointed commission to provide for benefits and to control costs; involves state health planning agencies.	All persons; eventually to replace Medicare and Medicaid.	90-day hospital services on a semi-private room basis; outpatient hospital services; home health care; physician services.	Not stated.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
Senator Edward Kennedy*	To bring high quality medical care to all persons, by 1975.	Implemented in stages. 1971: include coverage for all infants, preschool children, and adolescents in elementary and secondary schools; next 4 years expand at rate of 10 year age group per year.	Through federal general treasury revenues, with sufficient guarantees to avoid the vagaries of the appropriation process.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Federal financing.	1971: Preschool and school children; broadened each of next four years at rate of 10 year age group per year; eventually include entire population.	As comprehensive as possible.	Not stated.

<i>Plan</i>	<i>Purpose</i>	<i>How Implemented</i>	<i>Method of Financing</i>
AFL-CIO*	To provide a system of universal health care coverage for all persons.	A federal program allowing providers (physicians) to practice in the system on a full or part time basis, or of remaining out of system.	Tripartite basis: 1/3 employer; 1/3 employee; 1/3 general revenues.

<i>Government Participation</i>	<i>Who Is Included</i>	<i>Benefits Included</i>	<i>Annual Cost</i>
Federal management and control; somewhat similar to Medicare.	All persons.	Hospitalization; all physician services; extended care; custodial care; home health services; eye examinations; prescription drugs.	Not stated.

* Adequate details not available; material presented is taken from speeches, news releases, etc.

SENATE FINANCE COMMITTEE STAFF REPORT ON MEDICARE-MEDICAID—In response to a directive from the Senate Finance Committee, the professional staff of that Committee conducted an extensive inquiry into the status and operations of the Medicare and Medicaid programs. Press coverage of this report, such as it has been, has tended to be shallow. Editorial expression has been overly inclined

toward blind acceptance as bedrock fact the inferences and conclusions drawn by this report.

As a prelude to hearings conducted by the Finance Committee on diverse aspects of the Medicare and Medicaid programs including consideration of imposing ceilings on physician charges, the Committee staff report labors to lay the blame for the inadequacies of the program at the door step of all parties concerned

with the notable exception of Congress itself.

The report, numbering more than 300 pages, fails to give any significant attention to the effect of inflation, a condition brought on more by the extravagant spending programs authorized by the Congress than by any other single factor.

While your Committee on National Legislation has not yet formally responded to this report, the House may be assured that this matter and the hearings being conducted against the backdrop of this report will be discussed with members of the Georgia Delegation in the Congress on the occasion of the annual Washington luncheon meeting in April.

RECOMMENDATIONS

(1) Your Committee urges an expression on the part of individual physicians to their Congressmen on the desirability of Congressional adherence to the recommendations contained in the report of the Department of Health, Education and Welfare against inclusion of chiropractic in the Medicare program.

(2) Your Committee also recommends endorsement by the House of Delegates of the AMA Medicare plan as an acceptable alternative to the various national health insurance plans currently being offered.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee

Legislation Committee (State)

HARRISON L. ROGERS, JR., M.D., *Chairman*

The 1970 session of the Georgia General Assembly was described by one Atlanta newspaper as being more accurately characterized for what it failed to do than by what it did. Such was not the case in its disposition of medical and health oriented legislation. To the contrary, the General Assembly enacted many items of much needed legislation in the health field. Its awareness of the need to update and modernize many of Georgia's health statutes denotes a growing sophistication on the part of the Legislature.

There is an obvious increase in the interest of solving health care problems via the enactment of public statutes as manifested in the increased number of bills relating to health care introduced each year. This is no phenomenon peculiar to Georgia. It certainly exists on the national level and apparently exists in a majority of the states. Accordingly, the job of monitoring and influencing legislation of this nature will become more complex, requiring an increase in the amount of time and effort which must be forthcoming from all segments of the profession. Your Committee on State Legislation wishes to thank all those who contributed to the success of the program this past year and earnestly solicits the help and assistance of all physicians as the future of the profession is shaped in the chambers of the General Assembly.

The following is an attempt to account for the more important bills of concern to the medical profession considered by the 1970 session of the Georgia General Assembly:

COMPOSITE BOARD OF EXAMINERS (Medicine and Osteopathy)—H.B. 655, carried over from

the 1969 session of the General Assembly, will create a Composite Board of Examiners for medicine and osteopathy. As enacted, the bill contains the extensive amendments specified by the 1969 MAG House of Delegates as a conditional requirement for support by the Association.

Among the more important provisions of the bill is the right to enjoin anyone engaged in the illegal practice of medicine, a right not enjoyed by the Board of Medical Examiners prior to the enactment of this bill. In addition, it specified July 1963 as the cut-off date for the issuance of a license by reciprocity to an osteopath seeking full practice privileges in Georgia.

The bill further provides that the Composite Board of Medical Examiners shall inspect (or evaluate) and determine the good standing of all medical and osteopathic schools and internship programs not previously approved.

Future graduates of osteopathic schools will take the same examination for licensure (FLEX exam) as will be administered to graduates of M.D. schools.

Those osteopaths presently holding Georgia licenses will be given an opportunity to take 36 hours (clock hours) of refresher courses at the Medical College of Georgia or Emory to qualify for a full practice license. Those who do not avail themselves of these refresher courses may practice osteopathy only under a license that limits the scope of their practice. (This Bill passed and has been signed by the Governor.)

STERILIZATION—The 1970 amendments to the Georgia sterilization statutes will make possible the legal performance of a sterilization procedure in two significant areas not possible before to the enactment of this bill.

Prior to passage of the 1970 bill only married persons could be considered for sterilization (excepting eugenic sterilization in state institutions which has not been used in many years) and then only with the consent of the spouse. Under the new Act any person 21 years of age, married or unmarried, may request such procedure. If the subject is married the 21-year age requirement is not required. Whereas the old law made consent of the spouse an absolute requirement, the 1970 Act requires such consent only if the spouse can be located after a reasonable search.

The second important change relates to sterilization of the mentally incompetent. This obviously is a sensitive area and an acceptable bill was agreed to only after numerous conferences with religious and ethnic group leaders were held to give assurances of sufficient safeguards.

Among the numerous safeguards incorporated in the bill is appointment by the Court of Ordinary of two "disinterested" physicians to investigate the matter and report back to the Court, consultations, performance of the procedure in JCAH hospitals, adequate medical explanation of the medical consequences of such procedure, and, of course, written consent of the parents or guardians. (This Bill passed and has been signed by the Governor.)

VENEREAL DISEASE AND DRUG ABUSE TREATMENT—The 1969 General Assembly passed a bill to permit physician treatment of minors for venereal disease without parental consent. That bill was subsequently vetoed by the Governor.

The 1970 General Assembly passed an identical bill, except that it included treatment for drug abuse

as well as treatment for VD. Prior to this bill becoming law, non-emergency treatment given to a minor without parental consent would be viewed by the courts as a battery action and the physician would be subject to prosecution. This general provision of law remains applicable for all conditions except venereal disease and drug abuse.

Under the terms of this bill a physician is authorized to disclose or withhold from the parents and guardians information related to the treatment given. (This Bill passed, but was vetoed by the Governor.)

CLINICAL LABORATORIES—The 1970 General Assembly passed legislation to license and regulate the operation of clinical laboratories in Georgia. Legislation to accomplish this objective has a long history, having been first introduced four years ago.

The 1970 bill (S.B. 387) was the culmination of a year of hearings held in various parts of Georgia by a Joint Interim Study Committee of the Georgia House and Senate. It accomplished three principal objectives: First, it would license all clinical laboratories except those operated in licensed hospitals; operated by the State or Federal governments; operated for teaching or research purposes (involving no treatment of patients); *or operated in the offices of physicians exclusively in connection with the diagnosis and treatment of their own patients.*

Secondly, it provides that a physician must serve as the Director of a laboratory (with a "grandfather clause" that will permit anyone serving as a Director of a laboratory on the effective date of the Act to continue to serve in such position), except in the event the laboratory restricts its practice to dental pathology, the Director may be either a dentist or a physician. In addition, the Board of Health may promulgate regulations that would authorize persons possessing doctoral degrees in biology, microbiology and related fields to be Directors of clinical laboratories when the proper circumstances and qualifications are present.

The third principal provision is that the bill would require a license of all clinical laboratory Directors, and further, would authorize the Board of Health to set standards for laboratory supervisors. The Board is given broad regulatory powers for the implementation of this Act. (This Bill passed, and has been signed by the Governor.)

CADAVERS—The so-called "Dead Body" bill enacted during the 1970 legislature was written with a view toward increasing the availability of cadavers for use in medical and dental schools of Georgia.

Chapter 88-27 of the Code of Georgia stipulates that dead bodies under the control of municipalities and public institutions shall be delivered to the Anatomical Board for subsequent delivery to the medical and dental schools of Georgia. The bodies in question are obviously those to which no claim has been made by a relative or other person.

Under existing Federal law the Social Security Administration or the Railroad Retirement Board will pay a stated amount of money for burial purposes to a person making a legitimate claim to the body. Claims arising under this statute have resulted in an inadequate supply of cadavers for the medical and dental schools.

The purpose of the bill as written by MAG attorneys and passed by the General Assembly is to make

possible a payment to claimants of an amount of money equal to that paid by Social Security or Railroad Retirement. In return the claimant would forego this claim and the body could then be delivered to the Board for subsequent transfer to the medical and dental schools of the state. (This Bill passed, and has been signed by the Governor.)

PROFESSIONAL CORPORATIONS—The Professional Corporation Act, passed by the 1970 Legislature, permits a single professional practitioner to incorporate for the purpose of availing himself of tax and other benefits in the same manner that non-professional corporate entities are now permitted to engage.

Professional incorporation has been possible in Georgia since the enactment of the Professional Association Act of 1962 by the General Assembly. That Act, however, requires two or more professional practitioners for the purpose of incorporation. In addition, such groups have been under the scrutiny of and frequently engaged in litigation with the Internal Revenue Service to the extent that until a recent series of court cases that went against IRS, the matter of incorporation was not looked upon with great relish by many physicians.

This bill, like the 1962 Act, would in no way limit a physician's liability under malpractice, but rather addresses itself only to the business aspects of his practice.

By way of a "box score," there are 41 states that have enacted permissive legislation on this subject. (This Bill passed and has been signed by the Governor.)

CHIROPRACTIC—The chiropractic association sponsored legislation in the 1970 session that sought two objectives. It sponsored bills in the House and Senate to require inclusion of chiropractic services under the Title XIX, Medicaid program. And it sponsored legislation in the Senate only to compel insurance carriers to cover chiropractic services with all policyholders. Each of these three bills was defeated in committee and consequently never reached the floor of either chamber for a test of strength.

These same bills were introduced in the 1969 session of the General Assembly. It was obvious, however, that the "push" for these bills during 1970 session was more intense and every indication points to increased efforts by the chiropractors in the years ahead to persuade the Legislature to adopt these measures. (See recommendation one below.)

ABORTION—Efforts to liberalize Georgia's abortion laws were made on several occasions during the 1970 session. In essence, the bill offered sought to make abortion during the first 12 weeks of pregnancy a matter of simple arrangement between a woman and her physician.

MAG sponsored legislation on this subject two years ago and Georgia's updated abortion statutes are the result of that effort. MAG took no official position on the 1970 bill other than to indicate before a House Committee that it "had no enthusiasm for additional legislation on the subject of abortion during 1970" due in part to the fact that existing law had not been given sufficient time to prove if it was equal to the needs in this area.

Editorial support for this legislation plus the obvious aggressiveness of several groups campaigning for

enactment clearly indicate that the matter of relaxed abortion laws will come before the General Assembly again next year.

VISUAL ACUITY—In the area of traffic safety legislation a bill was passed to require all applicants for renewal of driver's license to submit to an examination to test visual acuity as well as examination on the "rules of the road." Such examinations would be given each five years.

Evidence of an examination for visual acuity given by a physician or optometrist within six months of the renewal date would be accepted in lieu of an examination administered by the Director of the Department of Public Safety. (This Bill passed, but was vetoed by the Governor.)

DOCTOR-OF-THE-DAY—Doctor-of-the-Day, a name given to the MAG program for staffing a medical aid station with volunteer physicians and nurses at the State Capitol during the session of the General Assembly, completed its second successful year during the 1970 session. The station was housed in vastly improved quarters and the equipment on loan from various surgical supply houses added greatly to the success of the project.

Your Committee wishes to thank all those who participated as volunteer physicians and pay a particular tribute to them all. The unselfish giving of their time and talent was a tremendous help to the overall MAG Legislative program.

COMMENDATIONS—The scope of MAG legislative involvement grows bigger each year. It would be impossible to get the job done without the help of many physicians at the "hometown" level and the MAG Auxiliary. Your Committee wants to thank these people sincerely and at the same time call particular attention of the House to the assistance given by Mr. John F. Kiser, Executive Secretary of the Fulton County Medical Society, Mrs. Talitha Russell, Executive of the Education Committee of the Georgia Society of Ophthalmology and Otolaryngology, and Mr. John L. Moore and his associates with the legal firm of Alston, Miller and Gaines.

Your Committee is once again in debt "up to its ears" for the fine work done at the Capitol by Mr. James Moffett during the 1970 Legislative Session. His accomplishments in searching out Bills related to the health of our citizens and insisting that our often "too busy" Committee review these bills are unsurpassed. Having accomplished this monumental task, he then carefully shepherds these bills during their legislative courses through the House and Senate Committees, getting reluctant physicians to appear before these groups when needed. When this part of the legislative process is complete, he then garners support or opposition to a particular bill for its vote on the floor of the House and Senate. His final step is to be sure the Governor is aware of the health implications of each bill which reaches his desk for signature or veto.

We offer our utmost appreciation for all his hard work.

RECOMMENDATIONS

(1) Your Committee recommends that all County Medical Societies be urged to meet with their State Representatives and Senators during the year for a frank discussion of chiropractic. There is every reason

to believe that 1971 is the target year for Georgia chiropractors to make an all-out effort to enact compulsory insurance coverage and Title XIX inclusion legislation. It is further recommended that the legislative Committee (under guidance of Council) be authorized to conduct a public information program designed to expose the true nature of chiropractic at such time and in such depth as fruitful returns may be anticipated.

(2) Your Committee recommends continuation of the Doctor-of-the-Day program at the State Capitol.

(3) Your Committee recommends that the various OB-GYN societies within the state carefully evaluate their position on the present and proposed legislation regarding abortion and make known their views before the 1971 legislature meets.

REFERENCE COMMITTEE RECOMMENDATION

—This report makes three recommendations. Specifically, it recommends that County Medical Societies be urged to meet with their State Representatives and Senators for a frank discussion of Chiropractic and further authorizes the State Legislative Committee to engage in an informational program designed to expose the true nature of Chiropractic. It is recommended that this portion of the report be *approved with commendation*.

Secondly, it recommended a continuation of the Doctor-of-the-Day program at the State Capitol during the sessions of the General Assembly and your reference committee recommends approval of this portion, with commendation, also.

With regard to recommendation number three, relating to abortion legislation, your committee recommends that this be stricken from the report and substitute in place thereof the following:

"That endorsement of the recommendation made by Reference Committee A on the subject of abortion, which this committee understands to be that a survey of the membership should be conducted to determine the consensus position of the profession on liberalized abortion legislation, and that the stated position of the Association conform to the results of this survey, be adopted."

HOUSE OF DELEGATES ACTION—Adopted the report with the substitute recommendation (3) as recommended by the Reference Committee.

Occupational Health Committee

TOM S. HOWELL, JR., M.D., *Chairman*

The growing complexity of problems related to the health and safety of industrial employees in Georgia is a matter of common concern for industry, government, and the medical profession. Advancing industrial techniques have introduced new problems such as hearing loss associated with excessive noise, air pollution, ionizing radiation, and man's reaction to many of the newer chemicals.

The Committee on Occupational Health is acutely aware of these health hazards and attention this year has been devoted to obtaining liaison between industry, government, and the Medical Association of Georgia.

A luncheon meeting was arranged and attended by representatives of the House and Senate, Georgia Business and Industry Association, Georgia Textile Manufacturers Association, Chamber of Commerce, Board

of Workmen's Compensation, and appropriate members of the Medical Association of Georgia. The primary purpose of this meeting was to make known to government and industry the Medical Association of Georgia's awareness of and willingness to assist in matters of occupational health.

The Occupational Health Committee would again like to call attention to inequities in payment under the Workmen's Compensation Act and would suggest a change to "usual and customary" rather than the "fee schedule." The Medical Association of Georgia should be advised that "unlimited medical" coverage may well be necessary before "usual and customary" can be adopted. A meeting is scheduled in April to include the directors of the Workmen's Compensation Board, industry, and representatives of the Medical Association of Georgia to further discuss this problem.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends adoption of this report with the following change: The sentence reading "The Medical Association of Georgia should be advised that 'unlimited medical coverage' may well be necessary before 'usual and customary' can be adopted." be deleted and in place thereof insert "The Medical Association of Georgia should be advised that the ceiling of medical coverage may have to be omitted before 'usual and customary' fees can be adopted."

Your Committee heard from several witnesses who expressed the opinion that the medical profession should not be called to subsidize industry in Georgia through a deficient Workmen's Compensation coverage level.

Your Committee concluded, therefore, that this House of Delegates urge Council, through its appropriate committee, to take a more active and aggressive role in helping to bring about "usual and customary" fees in Workmen's Compensation in Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report with the change as recommended by the Reference Committee, and the Reference Committee's further recommendation to Council.

Physician-Lawyer Liaison Committee

J. FRANK WALKER, M.D., *Chairman*

Joint efforts of the State Bar of Georgia and the Medical Association of Georgia have this year produced "*Principles Governing Physician-Attorney Relationships*." Following approval and adoption by each organization late in 1969, copies of these principles were sent to each attorney and each physician in the state.

The Committee will continue to attempt to mediate or arbitrate, in the first instance, any disputes arising between individual physicians and attorneys or between the two professions.

RECOMMENDATION

To the end of obtaining better understanding, professional cooperation and harmonious approaches to matters of interest, the Medico-Legal Committees of MAG and the State Bar of Georgia recommended the principles as standards of conduct for attorneys and physicians in interrelated practice.

REFERENCE COMMITTEE RECOMMENDATION
—In essence this report calls for House ratification and endorsement of an action of Council which was to adopt the new "*Principles Governing Physician-Attorney Relationships*." Your Reference Committee concurs in this recommendation and urges adoption with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

Resolution 70-5

Voluntary Proficiency Testing of Physician Office Laboratories

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, the quality of performance in clinical laboratories operated by the physician for his own patient is one of the most important parameters of medical practice, and

WHEREAS, various third parties and other agencies, including those of the federal government, have seriously questioned the accuracy of results obtained in medical laboratories, and

WHEREAS, there are increasing indications that these third parties and the public will demand assurance that their medical care is of superior quality, and

WHEREAS, some type of proficiency testing of the physicians' office laboratory is necessary to demonstrate and assure laboratory performance of the highest quality,

WHEREAS, quality assurance in all phases of medical care can best be implemented by Peer Review,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia endorses the principle of voluntary proficiency testing of the physicians' office laboratory,

AND BE IT FURTHER RESOLVED, that the Medical Review and Negotiating Committee develop without delay guidelines for proficiency testing in physicians' laboratories.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends adoption of this resolution by amending the last resolve to read as follows:

"AND BE IT FURTHER RESOLVED, that the Medical Review and Negotiating Committee in consultation with the Georgia Association of Pathologists and the Georgia Chapter of the American College of Physicians develop without delay guidelines for proficiency testing in physicians' laboratories."

HOUSE OF DELEGATES ACTION—Adopted Resolution 70-5 as introduced and rejected the change recommended by the Reference Committee.

Resolution 70-10

Repeal of State Laws on Serological Test for Syphilis as a Prerequisite for Marriage Licenses

WALKER-CATOOSA-DADE MEDICAL SOCIETY

WHEREAS, laws of the state of Georgia presently require a serological test for syphilis for both parties as a prerequisite for the issuance of a marriage license, and

WHEREAS, during the latest full year of this procedure, in excess of 117,000 such tests were performed, and

WHEREAS, only 95 cases of possible infectious syphilis were brought to treatment, and

WHEREAS, the current session of the State Legislature enacted a provision requiring the Board of Health in one county to operate a serology laboratory, and

WHEREAS, this action is an opening wedge for further encroachment of government upon the private practice of the healing arts, and

WHEREAS, the act gives authority to the governing authority of the county to establish fee schedules and hours of operation which make further encroachment upon private enterprises, now therefore,

BE IT RESOLVED, that the Walker-Catoosa-Dade Medical Society urgently seek the repeal of all laws and parts of laws pertaining to the requirement for serological tests for syphilis as a prerequisite for the issuance of marriage licenses, and

BE IT FURTHER RESOLVED, that the Medical Association of Georgia and the House of Delegates be urgently requested to support and further this endeavor, and

BE IT FURTHER RESOLVED, that the State Board of Health and the Georgia Department of Public Health by copy of this resolution, be requested to lend their support to this effort, and

BE IT FURTHER RESOLVED, that copies of this resolution be provided to the Medical Association of Georgia, the Chairman of the Georgia State Board of Health, the Director of the Georgia Department of Public Health and to the two State Senators and the four State Representatives serving the counties of Walker, Catoosa and Dade.

REFERENCE COMMITTEE RECOMMENDATION
—Your committee considered this resolution in full view of the realization that any change in this area is subject to misinterpretation.

After hearing several witnesses, however, your committee recommends adoption of a substitute resolution as follows:

WHEREAS, laws of the State of Georgia presently require a serological test for syphilis for both parties as a prerequisite for the issuance of a marriage license,

NOW THEREFORE BE IT RESOLVED, that the Medical Association of Georgia petition the Georgia General Assembly to enact legislation to require that the serology test for syphilis now required in obtaining a marriage license certificate be done in laboratories of the State Health Department at no cost to the individual.

HOUSE OF DELEGATES ACTION—Adopted and referred to the Council the substitute **RESOLUTION** as recommended by the Reference Committee.

Resolution 70-13

Chiropractic

SPALDING COUNTY MEDICAL SOCIETY

WHEREAS, "It is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease"; and

WHEREAS, the U.S. Department of Health, Education and Welfare, after an independent, unbiased study ordered by Congress, has found that "chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment"; and

WHEREAS, the report to Congress by HEW has received strong support from an ever-growing list of consumer and health organizations including, for example, the AFL-CIO, the National Council of Senior Citizens, the American Public Health Association, the Association of American Medical Colleges and the American Hospital Association; therefore be it

RESOLVED, that this House of Delegates, ever mindful of its obligation to protect the public health, calls upon each state medical society to take whatever steps are necessary to stop the licensing of chiropractors;

AND BE IT FURTHER RESOLVED, that the MAG Delegates to the AMA House of Delegates be urged to introduce this resolution at the 1970 Annual Convention of the AMA as the first important step toward placing the medical profession on a nationwide offensive against the menace of chiropractic.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee approves with commendation this resolution and urges its adoption.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-15

GaMPAC Commendation

FULTON COUNTY MEDICAL SOCIETY

WHEREAS, the medical profession has a growing, recognized interest in political activity at all levels, and

WHEREAS, the Georgia Medical Political Action Committee was created to serve the profession as a non-partisan vehicle for the effective expression of political action; and

WHEREAS, GaMPAC has demonstrated over the years its capacity to effectively influence the outcome of Congressional and State House elections; and

WHEREAS, GaMPAC's ability to remain a strong, viable and aggressive organization to the end that the profession's views concerning improved patient care, maintenance of the free enterprise system and continuation of the progress of medicine, is in direct proportion to the extent of support given to GaMPAC by individual medical practitioners,

NOW THEREFORE BE IT RESOLVED, that the MAG House of Delegates reaffirms its endorsement of the GaMPAC concept, and urges all physicians to actively support GaMPAC through membership contributions.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee approves this resolution with commendation and urges its adoption.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Chairman McEver then stated that he wished to thank all the members of the Committee for their tireless efforts and also expressed on behalf of the full Committee their appreciation to the witnesses for their time and efforts in helping develop the recommendations of the Committee on all the matters presented.

Chairman McEver then moved the adoption of the Report of Reference Committee C in its entirety. The motion was duly seconded and adopted.

Report of Reference Committee D

Menard Ihnen, M.D., Chairman

Chairman Ihnen reported to the House that reports and resolutions referred to Reference Committee D had been considered by the Committee which met at 9:00 a.m., in the Surrey Room A, Carriage Inn, on May 9, 1970, Jekyll Island. Members of the Committee present included: Menard Ihnen, M.D., Augusta, Chairman; Bill Burcell, M.D., Calhoun, Vice Chairman; J. Emmett Collins, M.D., Manchester; C. A. Wilson, M.D., Brunswick, J. S. Wilson, M.D., Atlanta and F. Debele Maner, M.D., Savannah.

Second Vice-President

F. W. DOWDA, M.D., Atlanta

In general, the administrative staff of the Medical Association of Georgia has impressed me as being one of the best in the nation and I have no comment other than this to make on them.

There is one point that I think needs to be brought to the membership in general and that is the continued inability of the Medical Association's Fee Negotiating Committee to obtain usual and customary fees for Workmen's Compensation. Although our structure in Georgia certainly is better than in many states and it is a considerable improvement in what it has been before, there seems to be little reason to me why doctors should continue to subsidize businesses in this state which can well afford to pay for adequate and complete insurance. In addition to this, the Workmen's Compensation Board has adopted a coding of procedures which would be totally unnecessary if they would accept the Medical Association of Georgia Fee Negotiating Committee as their utilization review body and under these circumstances, competent physicians could decide on the justification of fees and appropriate guidelines could be set up.

RECOMMENDATION

I recommend to this body that we recommend to the Vocational Rehabilitation Board that they accept the Medical Association Fee Negotiating Committee as their utilization review body and begin to pay usual and customary fees without the coding of procedures.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report with a change in the recommendation so that it would read as follows:

"I recommend to this body that we recommend to

the Workmen's Compensation Board that they accept the Medical Review and Negotiating Committee as their utilization review body and begin to pay usual and customary fees without mandatory coding of procedures."

HOUSE OF DELEGATES ACTION—Adopted the report with the changes as recommended by the Reference Committee.

Cancer Committee

HOKE WAMMOCK, M.D., Chairman

The Committee on Cancer held two meetings during the year. These meetings were comprehensive, and we endeavored to explore all possibilities related to cancer control in Georgia. Remember, 13,000 new cancer cases develop in Georgia annually.

The role of the Committee on Cancer in the past has been in an advisory capacity to the State Public Health Cancer Control Program, "State Aid Cancer Control." However, with the enactment of the Medicaid and Medicare program, Regional Medical Program (Heart, Cancer and Stroke), the Georgia Division of the American Cancer Society and its Regionalization Program, the Regionalization Program of the American College of Surgeons with its Liaison Fellows of the Georgia Chapter of the American Cancer Society, the activities and responsibilities of the Committee have been multiplied. There is an interdisciplinary relationship between these various groups and organizations concerned with cancer control. Many committee members hold multiple committee appointments in these various agencies and groups. In view of this, we invited representatives of these various groups and organizations to meet with us. This proved to be most helpful in the exchange of ideas and in the planning of cancer control in Georgia. I believe it can be stated without contradiction that in Georgia we have one of the best coordinated cancer control programs in the U.S. We are able to utilize the counsel and advice of many individuals involved in cancer for a progressive program in Georgia.

In reviewing the activities of the past and making plans for the future, it is incumbent upon us to encourage the development of adequate physical facilities, to see that continuing education programs are developed and expanded by the utilization of Seminars, consultants and the development of clinical activities programs (tumor conferences), the development of tumor registries. The importance of the latter cannot be underestimated, for it is from the tumor registries that we can pool information that can be fed back to the physician.

The Chairman has had conferences and visits from officers of the American College of Surgeons in reviewing the Cancer Control Program in Georgia, and they have been most complimentary.

The State Aid Cancer Control Program, under the State Public Health Department, has been of inestimable value in cancer control in Georgia, providing cancer detection and treatment for the indigent patient. It is actually around this program that the State Aid Cancer Clinics in Georgia were developed. However, with the Medicaid and Medicare Programs this has brought about some reduction in the case load, but I call your attention further to the fact that by 1972 the Cancer State Aid Program will come under the

Medical Assistance Program of the State Public Health Department. To what extent this will affect Cancer Control in Georgia remains to be seen. We must work harder in every way to maintain the best tumor clinic activities possible.

What are some of the accomplishments in Cancer Control during the past year?

The Third National Cancer Survey, under the sponsorship of MAG and GRMP, is functioning well and is confident of accomplishing its mission of coding pertinent information on all incidents and prevalent cancer cases in the metropolitan Atlanta area between 1969 and 1972. Cancer deaths are also being recorded and a 10 per cent randomized interview study on the economic aspects of this disease is being conducted.

The Regional Medical Program has been of invaluable assistance to Cancer Control. There are now 12 designated Area Facility Programs in operation that meet the standards and regulations of the American College of Surgeons for operating a tumor clinic or a Clinical Activities Program. It is planned that additional Area Facility Programs will be designated in the very near future.

Seminars have been held throughout the state on various topics of cancer. These Seminars have been well attended. The tumor registries of the 12 Area Facilities have been updated for 1967, 1968, and 1969, and very soon a printout will be available on the end results. This is going to provide valuable information for feed-back to the medical staff of the various Area Facilities and eventual feed-back to the physicians in the state.

Seminars have been held for tumor registry secretaries to provide us with more competent personnel for the operation of the tumor registries.

Last summer, medical students were procured to work in the Area Facility Programs in updating their tumor registries. The participation of the medical students in this activity proved to be of mutual benefit, not only to the Area Facility Programs, but also to the medical students. These students were hungry for knowledge in the field of cancer.

The Committee endorsed the plan of having medical students work in the Area Cancer Facility Programs and that this be continued whenever possible.

The Committee further recommends that the American Association for Cancer Education, through the respective medical schools, continue their efforts in planning a cancer teaching program, that cancer is a multidisciplinary course and should be taught as such, and that efforts be made to expose students to more cancer, particularly by rotating through cancer clinics.

The Georgia Division of the American Cancer Society is engaged in both lay and professional education and providing of service on a limited scale to cancer patients.

In cooperation with the Atlanta Graduate Medical Assembly, a one-day Cancer Program was held and the Cancer Committee wishes to commend the Georgia Division of the American Cancer Society and the Atlanta Graduate Medical Assembly for such an excellent program. We urge that this type of program be continued on an annual basis.

It is recognized that early detection and adequate treatment plays a vital part in the survival of the cancer patient. We must take recognition of the fact that

in the treatment of cancer, extended radical procedures are employed and we should make every effort to see that the patient is rehabilitated. We heartily endorse and recommend the utilization of the Reach to Recovery Program of the American Cancer Society, that it be utilized to its fullest advantage in the rehabilitation of the cancer patient.

We recognize the fact that the incurable cancer patient presents a problem in providing palliation and that every effort should be made to utilize the services of the patient's family and agencies wherever possible in the Extended Care Service.

RECOMMENDATIONS

Your Committee has reviewed the Cancer Control Program in depth and it has peered into the future. We wish to make the following recommendations:

1. That every effort be made to strengthen the tumor clinic.
2. That physical facilities be expanded and modernized.
3. Cancer detection facilities should be made available to all.
4. That the clinics and hospitals develop a tumor activities program.
5. That continuing education of the medical staff be explored and developed.
6. That Medical Schools review the cancer teaching program to improve learning in the subject of cancer.
7. That rehabilitation of the cancer patient is of great importance in restoring the patient, and we heartily endorse the program of Reach to Recovery of the American Cancer Society.
8. That every effort be provided for the care of the incurable patient, utilizing all available agencies, such as the public health nurse, local units of the American Cancer Society, welfare agencies, and others.

We have an excellent Cancer Control Program in Georgia, much has been gained, but we have more to do.

The Chairman wishes to express his appreciation to all the members of the Committee on Cancer and to the officers of the Medical Association of Georgia for the fine spirit of cooperation in providing better medical care.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation of this report, for the Cancer Committee's excellent work throughout the year.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

Insurance and Economics Committee

WILLIAM W. MOORE, JR., M.D., *Atlanta*

The Committee met formally in July, October and March. The Committee has principally been concerned during the past year with investigating and confirming the necessity for rate increases in the MAG's major hospital and nursing care plan and in our policy with St. Paul Insurance Companies for professional liability insurance. In both instances, confir-

mation of the economic facts at hand were found to justify the requested rate increases and detailed consideration was given in both instances to utilization of every available means to control as best as possible the need for further increases. It should be clearly recognized, however, that the existing trend in hospital costs and the existing trends in professional liability suits and settlements afford strong indication that a continuing rise in the cost of these policies is highly probable if not certain since the majority of factors relating to their cost are not controllable items.

In the course of the year the Committee has additionally considered upon request from members within and outside the Committee problems relating to the shortage of hospital beds, the establishment of criteria for school insurance (namely that such plans should provide usual and customary fees, cover all injuries usually sustained by school children on the basis of experience and should contain a deductible feature). The Committee Chairman attended on behalf of the Association the Fourth National Congress on the Socio-Economics of Health Care which was a two-day seminar setting out a variety of perspectives on various problems with which we are all acutely familiar. The importance of providing comprehensive health insurance which includes out-patient care on an ambulatory basis with responsible utilization of peer review would seem to be the best and most likely obtainable goal for organized medicine to pursue in order to deal as responsibly as possible with the multitude of problems besetting us.

The Committee again wishes to express its appreciation for the staff work and effort provided by the Executive Director and for the extremely proficient and helpful professional help given to us by our consulting actuary, John Glenn.

RECOMMENDATION

The appointment of a study committee to report to the Committee on Insurance and Economics concerning feasibility of establishment of a MAG sponsored comprehensive prepaid medical insurance program. In such a study actuarial assistance beyond the ordinary scope of our present arrangements for such advice should be anticipated.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report, with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

Medical Review and Negotiating Committee

JOHN R. MCCAIN, M.D., *Chairman*

Your Committee on Medical Review and Negotiating has had its most active year during 1969-70, and this report will present in summary from the results of many hours of work by the Committee members and the MAG Staff assigned to the Committee. The Committee Vice Chairman, Frederick A. Carpenter, M.D., resigned on leaving the state and the Committee is most appreciative of the work of Richard A. Elmer, M.D., who was elected Vice Chairman and moved immediately into the work of leading this active group.

The Committee's work in the area of reviewing in-

jectible medications resulted in tangible guidelines for the parenteral administration of B-12. These guidelines have been distributed to all third parties.

The Committee was once again the principal sponsor, along with the Health Insurance Council of Georgia, of a one-day conference on Peer Review. This meeting held at the Atlanta Marriott was designed to school local and district committees, and attracted some 50 participants.

Peer review activity has generated much interest and attracted national attention. So much so that the AMA sponsored a National Conference on Peer Review just preceding its 1969 clinical meeting. As Chairman of this Committee it was my privilege to represent MAG at that conference. As a result, it was possible to secure Dr. John Rumsey, Chairman of the AMA Council on Medical Service, as a conference program participant in Georgia.

Liaison with third parties including Medicare, Medicaid, Workmen's Compensation Board, CHAMPUS, etc. has been a function of this Committee and those contacts have been fruitful for the Association. This year has seen a change in carrier for Medicine-B and previous contacts with the Bureau of Health Insurance enabled the MAG office to learn of the change before it was announced in the existing carrier's own office. Meetings have been held with principals of the new carrier, the Prudential Insurance Company, in order to establish a rapport with the new leadership.

Much attention has been placed by the Committee on the new California Relative Value Study and the AMA's Current Procedural Terminology, both which contain new 5-digit coding and nomenclature. The committee has voted its endorsement of the new coding and nomenclature and has received Council's endorsement.

With the continued growth of federal government third party medical care programs, the Committee will seek approval of an expanded scope of responsibility in order to present proposals to those third party programs for MAG to be designated the agency to conduct Peer Review of all claims. This will require much time and effort by members of this Committee and staff, but the lessons of the history of this Committee are that a thorough job will be done. The sincere appreciation of the Chairman goes to all the members who have contributed to our success this year.

A particular note of appreciation goes to our MAG Executive Director, Edwin Smith, and to CHAMPUS Administrator, Mrs. Joyce Butler. It would be difficult to work as effectively or to plan as adequately, were it not for the efficient work of Mr. Smith and his capable staff.

RECOMMENDATIONS

1. That all physicians be encouraged to adopt for their personal use the 1970 AMA Current Procedural Terminology, containing 5-digit coding and nomenclature, for all claims submitted from their office, and that MAG encourage third party acceptance of that document as the basis for receipt of all claims.

2. That the MAG Executive Director be authorized to increase the MAG staff to provide for a lay coordinator of Peer Review with Secretarial and other support staff as required to administer that project for third parties.

3. That the scope of responsibility of the Committee on R. and N. be expanded to include all matters regarding "Peer Review," including certification of usual, customary or reasonable fees, utilization of manpower, medications, and facilities, and appropriateness of care rendered.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation of this report, citing Dr. McCain and his committee for their excellent work.

HOUSE OF DELEGATES ACTION—Adopted the report after amending the second recommendation by adding the words "contingent upon funds being made available from Medicaid."

Resolution 70-1

Peer Review

COBB COUNTY MEDICAL SOCIETY

WHEREAS, control of the quality and the cost of medical care are the legitimate concerns of organized medicine; and

WHEREAS, a physician's performance is best judged by his fellow physicians—his peers—who possess similar training and experience; and

WHEREAS, effective peer review can be achieved only with the cooperation of all physicians; therefore,

RESOLVED, that willingness to participate in an on-going program of peer review operated by the Medical Association of Georgia be made a condition of membership in the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution by deleting the RESOLVED and inserting the following:

"RESOLVED, that all physicians be encouraged to participate in an ongoing program of Peer Review."

HOUSE OF DELEGATES ACTION—The House of Delegates adopted the resolution with the change as recommended by the Reference Committee.

Resolution 70-11

MAG Establish a Committee on Private Practice

COBB COUNTY MEDICAL SOCIETY

WHEREAS, the American Medical Association established a committee on Private Practice in December, 1969, and urged the development of similar committees by state medical societies; and

WHEREAS, the objectives of the AMA Committee on Private Practice are similar to the objectives of the Medical Association of Georgia Committee on Separate Billing,

THEREFORE BE IT RESOLVED, that the name of the MAG Separate Billing Committee be changed to the MAG Committee on Private Practice.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-14

Let the Bedside Physician Be the Guideline

GEORGIA MEDICAL SOCIETY

WHEREAS, the Georgia Medical Society in thought, word and deed has always striven to realize in our community a high quality of medical care for the sick and needy, and has repeatedly warned that only the bedside physician can accurately judge the needs of the sick patient; and

WHEREAS, the federal government and Congress made a commitment to support medical care financially, through Medicare and Medicaid, without interfering in the doctor-patient relationship and working in conjunction with the Society Security Agency and designated private carriers charged with financing these services, have evolved a system of so-called guidelines which serve to limit these services through the device of vaguely defined words, such as "custodial care," and substitutes cold, heartless and remote bureaucratic judgment based on paper forms, for the warm, sympathetic and understanding counsel of the attending physician; and

WHEREAS, this state of affairs is intolerable and in dire need of redress; then

BE IT RESOLVED, that we, the members of the Georgia Medical Society, in full meeting assembled, do hereby declare that at the inauguration of the Medicare-Medicaid programs we, as physicians, along with the visiting nurses and other paramedical personnel, geared ourselves to extend our services to the fullest of our resources in keeping with the highest standards of medical practice, now request that the federal bureaucracy remove itself from the task of decision-making where patient care, both as in-patients and those receiving home nursing, is affected, and return this to the only ones capable of the proper judgment in these matters, the bedside physician; and

BE IT FURTHER RESOLVED, that our intent and resolve be communicated to the Medical Association of Georgia, urging upon that august body a similar action and that this resolution be promulgated to all state and local societies, to the American Medical Association and to members of the Congress and the Federal Government, that they, all seeing these intolerable inconsistencies, might give us reprieve.

Let our ideals not be denied,
Let the bureaucrat's grip be defied,
May the patient's neglect be decried,
Lay the cold-hearted forms aside,
Let the bedside physician decide.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-17

Workmen's Compensation

FULTON COUNTY MEDICAL SOCIETY

RESOLVED, the Medical Association of Georgia endorses usual and customary fees for physicians un-

der Workmen's Compensation rather than an arbitrary scale; and

BE IT FURTHER RESOLVED, the Medical Association of Georgia reiterates its feeling that the primary contract is between the physician and the patient and not with the insurance company; and

BE IT FURTHER RESOLVED, the Medical Association of Georgia recommends that Workmen's Compensation insurance forms not make unusual secretarial or clerical demands upon physicians (i.e., multiple code schedules and multiple copies).

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution with amendments to the third RESOLVED as follows:

“BE IT FURTHER RESOLVED, that the Medical Association of Georgia recommend that the Workmen's Compensation Board cooperate with the MAG in adopting forms and code schedules that do not make unusual secretarial or clerical demands.”

HOUSE OF DELEGATES ACTION—Adopted the resolution with the changes recommended by the Reference Committee.

Resolution 70-18

Fraud Disclaimer on Medicaid Claim Forms

HALL COUNTY MEDICAL SOCIETY

WHEREAS, there has been no instance of physician fraud in the Medicaid program in Georgia; and

WHEREAS, the physicians of Georgia have participated and cooperated with the Medicaid program to the fullest with integrity and honesty; and

WHEREAS, the physicians of Georgia bitterly resent the implied perpetration of fraud by HEW's newly instigated fraud disclaimers on the Medicaid forms; and

WHEREAS, the proposed HEW fraud disclaimer for Medicaid claim forms, to become effective April 1, changes no material fact, is completely unnecessary, and represents a further attempt by the federal government to undermine the medical profession in the public view; therefore

BE IT RESOLVED, that the members of the MAG will sign such a statement only under vigorous protests; and

That the MAG will lodge a strenuous protest with HEW, and pursue all possible avenues to have such a statement stricken from the Medicaid forms in the future.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-19

Support of Hospital Utilization and Review Committees

CHEROKEE-PICKENS COUNTY MEDICAL SOCIETY

WHEREAS, great emphasis is being consistently

placed upon hospital Utilization and Review Committees by both fiscal intermediaries and hospital administration; and

WHEREAS, diligent peer group evaluation is being accomplished at the local Utilization and Review Committee levels; and

WHEREAS, proper local medical staff evaluation and approval or disapproval regarding effective utilization is being properly documented by records and minutes; and

WHEREAS, consistent requests for re-review and justifications from fiscal intermediaries are placing a burden upon the Utilization and Review Committees while apparently questioning the judgment, capabilities and validity of said committees; therefore

BE IT RESOLVED, that this Body does support and strive to uphold the purpose of and redeem by ethical means, the respect from fiscal intermediaries, and their Medical Advisory Staffs as is due the Hospital Utilization and Review Committees, their functions and intents.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution with amendment to the RESOLVED to read as follows:

“BE IT RESOLVED, that the House of Delegates request Council to initiate dialogue with fiscal intermediaries to minimize the burden placed upon the Hospital Utilization and Review Committees.”

HOUSE OF DELEGATES ACTION—Adopted the resolution with the change recommended by the Reference Committee.

Chairman Ihnen then stated that this concluded the report of Reference Committee D and that he wished to thank the members of his Reference Committee for their time and efforts. Chairman Ihnen moved the adoption of his Reference Committee's report as a whole. The motion was duly seconded and adopted.

Report of Reference Committee E

Frank L. Wilson, M.D., Chairman

Chairman Wilson reported to the House that the Reports and Resolutions referred to Reference Committee E had been considered by the Committee which met at 9:00 a.m., in Surrey Room B, Carriage Inn, Jekyll Island, on May 9, 1970. Members of the Committee present included Frank L. Wilson, Jr., M.D., Atlanta, Chairman; Henry C. Drake, M.D., Macon; Frank R. Mann, M.D., McRae; and Jack R. Meacham, M.D., Summerville.

Cobb County Medical Society Councilor

W. C. MITCHELL, M.D., Smyrna

The Cobb County Medical Society continues to gain in membership, over 18 per cent this past year, from 140 to 165 members. As in most other localities, the increase is not enough to keep up with the population growth and still give the services demanded by the present day economy.

Dr. Remer Clark, the Vice Councilor, has been of great help during this past year. He has attended every one of the Council meetings and was well versed in reporting on what went on to the County meetings and was successful in getting in most of the delinquent assessments.

I have attended all of the Council meetings, as well as the June meeting for all the committees, the leadership conference meeting, and served at the Capitol as Doctor of the Day one time during the meeting of the General Assembly. I have thoroughly enjoyed all meetings attended and have considered it a privilege to represent Cobb County and the Medical Association of Georgia.

Cobb County Medical Society meets every other month, and the meeting is a combined social and scientific affair, and the attendance has been unusually good. The month that the society does not meet, the executive board meets and carries on the business part. Dr. Clark, the Vice Councilor, and I have requested that both of us be notified of these meetings, in order that one of us may be present and report to the group as to what is going on in Council. This will also enable us to be more familiar with what is going on at the local level and to have the benefit of the thinkings of the officers which will in turn help us in our Council deliberations.

The Cobb County Medical Society, along with the lawyers, ministers, and the Kennesaw Junior College will again this year conduct its annual Symposium. Symposium '70 has for its theme "Frontiers of the Mind." It will be held April 16 and 17 at Kennesaw Junior College. The program will be centered around five outstanding speakers. The public is invited and if the four previous Symposiums are any indication, I am sure it will be well accepted.

Again let me say it has been an honor and a privilege to serve on the Council as the representative of Cobb County and I'm sure I may say the same for the Vice Councilor, Dr. Remer Clark.

RECOMMENDATIONS

- (1) Continue in our efforts toward better public relations.
- (2) Make an effort to get more of our members involved. That is, involved in *their* Medical Association. Let's have something for everyone to do and let's make all our members part of the establishment as well as one of "The Clique."

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1969		Members December 31, 1968	
	MAG	AMA Dues Paying Only	MAG	AMA Dues Paying Only
Cobb				
Stephen C. May, Jr.				
Kennesaw	155	145	140	135

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the report as recommended by the Reference Committee.

Emergency Medical Services Committee

FLEMING L. JOLLEY, M.D., *Atlanta*

The Committee has developed with the commendable assistance of the Department of Public Health a composite desk brief of background material for the County Medical Societies. These briefs are currently being distributed by Mr. Carl Bailey.

Several important legislative measures were passed by the 1970 Assembly. Governor Maddox vetoed the important visual re-examination bill after passage by the House and Senate.

Participation in various local, regional, and national medical society and association meetings has been made by members of this committee.

RECOMMENDATIONS

(1) Three resolutions will be introduced relative to ambulance services, the visual re-examination, and medical advisory board legislation for 1971. The endorsement of these resolutions by the House of Delegates is recommended.

(2) The committee also recommends to the county societies that careful consideration be given to the appointment of motivated members to emergency medical services and traffic safety committees. These committees should be involved in community activities upgrading ambulance services and emergency clinic services.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted this report as recommended by the Reference Committee.

Public Service Committee

TULLY T. BLALOCK, M.D., *Chairman*

The MAG Public Service Committee sponsored the Annual County Society Officers Conference, which was held at the Sheraton Biltmore, Feb. 14-15, 1970. The Conference was well attended and presented an excellent program of information to the new county society officers. Copies of several of the talks have been submitted to the Editor of the *MAG Journal* with the hopes that some of them can be published in the *MAG Journal*.

The Public Service Committee published a County Society Officers Handbook which was distributed to each officer attending the County Society Officers Conference. Those county society officers not attending the conference will receive a County Society Officers Handbook during the regular field visits.

The Committee purchased M.D. bumper stickers which are available to MAG members upon request.

RECOMMENDATION

The Public Service Committee would like to recommend that the County Society Officers Conference be continued as an annual event.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this report.

HOUSE OF DELEGATES ACTION—Adopted the Report as recommended by the Reference Committee.

School Child Health Committee

FRED L. ALLMAN, JR., M.D., *Atlanta*

The function of the School Child Health Committee of the Medical Association of Georgia during the past year has been to stimulate cooperation by individual physicians in the School Child Health program, to keep the profession informed on school health programs, and to report to the profession on progress. Our Committee has improved its relations with the Dental Association, school systems, health department, parents groups, Georgia high school association and other appropriate organizations.

Specifically, the Committee has accomplished the following during the past year:

Follow Up on Existing Projects

Smoking and Health: The teachers resource kits, which were placed in the schools in 1967, in cooperation with the State Department of Education, Georgia Heart Association, Georgia Tuberculosis Association, Georgia Cancer Society and the State Health Department have continued to be utilized in many schools throughout Georgia and have been used as a model for other states.

Medical Aspects of Sports Conference: The Medical Association of Georgia through the Committee on the Medical Aspects of Sports, through the School Child Health Committee, again sponsored a post-graduate course on the Medical Aspects of Sports. This was held in Macon, Georgia, August 8, 1969. Members of the Committee, other members of the Medical Association of Georgia, athletic trainers from the University of Georgia, Georgia Tech, Auburn and Virginia, joined with Dr. Frank C. McCue, Orthopedic Surgeon and team physician for the University of Virginia athletic teams, in presenting a very interesting and worthwhile program. Again, a highlight of the meeting was a luncheon which was co-sponsored by the Health Department under the supervision of Mrs. Mary Helen Goodloe and the Coca-Cola Company. Over 100 coaches and physicians attended the luncheon and participated in an informal discussion on Nutrition for the Athlete.

Guide for Medical Evaluation: The Committee is continuing its efforts to have the American Medical Association guide for medical evaluation for candidates for school sports made available to all participants of athletic schools throughout our state and that the forms contained therein be the minimum information furnished for each candidate for the athletic team.

Classification of students for physical education: The Committee continued its efforts to formulate an acceptable form that will be suitable for all physical education programs throughout the state.

The Medical Aspects of Little League Baseball: The Committee sponsored a two-day program on the medical aspects of Little League baseball in Atlanta, March 20, and March 21, 1970. This is the first time in the history of the Little League that a program devoted exclusively to the health implications of Little League participation has been presented. Participants were given guidelines for proper program for injury prevention, diagnosis, treatment and rehabilitation. National representatives of Little League, Inc. and Little League coaches and managers from eight of

Georgia's 10 districts were on hand to hear Dr. Thomas Schaffer, Pediatrician from Columbus, Ohio, talk on "A Physician Looks at Little League" and "The Medical Evaluation for Little League Participation." They also heard Dr. Hugh Tullos, Orthopedic consultant for the Houston Astros baseball team, speak on the "Mechanism of Injury in the Throwing Arm." Rules, regulations, safety through proper protective equipment and playing facilities, as well as instruction in closed cardiac massage and artificial resuscitation were among the other subjects covered.

Dangerous and harmful drugs by school children: Recognizing the increased usage of dangerous and harmful drugs by school children, the Committee has cooperated with numerous other groups and agencies including the State Department of Education and the State Health Department, in preparation of material and dissemination of this material to each school in Georgia. The Committee plans to continue to support other agencies involved in the drug problem and feels that there is no need at the present time to undertake any additional program on its own.

Heat and the athlete: The Committee again made available through the State Health Department and the State Department of Education the *JMAG* article on "Heat and the Athlete." This was distributed to every high school in the state. Last year four deaths occurred to athletes throughout the nation as the result of heat stroke. These are preventable deaths, and the efforts of all physicians should be directed to total elimination of these unnecessary deaths in athletes.

Health insurance for athletes: The Committee continues to feel that more efforts need to be directed toward improving health insurance coverage of our athletes. Many communities and many schools have inadequate insurance or other means to care for severely injured athletes. Consideration should be given to a preliminary hearing of school administrators, coaches, parents, physicians and others to discuss this apparently increasing need.

Dissemination of educational material to parents, coaches and other physicians: Efforts are being continued to overcome the information gap which exists between known medical needs and their direct application to the athlete. The Committee hopes to be able to implement the plan, which was proposed in last year's report, to have small meetings in each section of the state concerning the medical aspects of sports.

Future Projects

The Committee will again present a *Conference on the Medical Aspects of Sports* in Macon, Georgia, August 6, 1970. All physicians and coaches are urged to attend this meeting.

The medical aspects of Midget Football: A meeting on the medical aspects of Midget Football will be held in late July or August, 1970, to inform coaches, parents, administrators and physicians on the necessity and method of proper supervision for these activities.

The Committee wishes to continue to urge the Georgia High School Coaches Association to establish *certification requirements for coaches* that would require minimum standards of instruction in important subjects, such as first aid, health and injury prevention. In order to provide ample opportunity for coaches to satisfy their needs of continuing education in the field, a

course is being established at Georgia State University on "The Medical Aspects of Sports." When successfully completed, this course will offer credit toward a Master's Degree.

A course for "Physician Attendance at Athletic Events": The Committee plans to offer a 15 hour course for Physician Attendance at Athletic Events. This will be a pilot project, and will attempt to establish standards, curriculum and text material which might be used in other areas of the state in a similar manner. Physicians who successfully complete the course will be given a certificate which recognizes their qualifications to serve as a medical attendant at an athletic event.

Television series on the Medical Aspects of Sports: Arrangements are currently being made with the state education TV station to produce a series of programs on the Medical Aspects of Sports to be shown at the beginning of the football season, 1970. Subjects to be covered are pre-participation physician examinations, heat stress, head and neck injuries, knee injuries and proper conditioning routines.

Pre-school screening of vision and hearing: The Committee during the past year has held two contact meetings with all interested groups concerning pre-school screening of vision and hearing. The Committee has concluded that such a program will not only be very beneficial to the children who need help, but would also create a good public image for the Medical Association of Georgia. The Committee has been impressed with the work being done in Minnesota by their medical association, and feels that a plan similar to theirs would be equally successful in Georgia.

RECOMMENDATIONS

This Committee, therefore, recommends that the Medical Association of Georgia sponsor such a program for pre-school screening of vision and hearing. We recommend that the Medical Association appoint a board of trustees to serve as a governing body for this project. The board should consist of three representatives of the Georgia Society of O&O, one representative from each of the two medical schools, two representatives of the Medical Association of Georgia, at least one of whom will be a member of the School Child Health Committee, and a representative of the Medical Advisory Committee of the Georgia Society for Prevention of Blindness.

Following the establishment of such a board, an advisory committee composed of the in-agency groups which have been present at our two previous meetings, and including a representative of the Georgia Association of Parent Teachers and the Georgia Jaycees, should be formed. The board, with advice and aid from the advisory committee, will then establish policy and procedure and begin the pre-school screening of speech and hearing in Georgia. All members of the Committee are enthusiastic about this project and hope that the Medical Association of Georgia will give its full support and cooperation to this very worthwhile endeavor.

The Committee wishes to assume the responsibility for passing on the data included in Resolution 112 and Resolution 89 of the House of Delegates of the American Medical Association at its most recent meeting. This resolution being as follows:

"Resolve that the Board of Education of the Department of Health of the individual states be urged to establish an adequate athletic medicine unit in every school that mounts the sports program, and be it further resolved that the athletic medicine unit be composed of a duly licensed physician and athletic health coordinator and other necessary personnel, and be it further resolved that the duties of the athletic unit be the prevention of injury, the provision of medical care with the cooperation of the family physician and under the health care team of the community, and the rehabilitation of the injured. And be it further resolved that the athletic units be required to submit complete reports of all injuries to the respective State Department of Health, and be it further resolved that the medical schools be urged to assume the responsibility of educating athletic health co-ordinators as well as specialists in athletic medicine. And be it further resolved that copies of this resolution be forwarded to the Governor, the Legislature, the State High School Athletic Association, the Department of Health, the Board of Education, the Association of School Boards and Association of Administrators of the Schools or the equivalent in each state."

"Resolution 89—that the board of trustees request a committee on Medical Aspects of Sports to utilize and publicize existing research on football head injuries in order to recommend minimum standards for the football helmets in order to provide protection against impacts which cause head and neck injuries."

The Committee fully realizes the importance of the resolutions and intends to see that this information is disseminated to the proper authorities and to aid in the implementation of the subject matter to the very best of its ability.

The Committee would like to thank the Medical Association of Georgia for providing necessary funds for the operation of this very important committee, and would like to thank all the members of the Medical Association for cooperating with the projects which have been submitted. The Committee would like to urge each member of the Medical Association to help develop the integrated relationship of health and education. There can be no question that one needs to be educated in order to develop and protect one's health, and one needs abundant health to make full use of one's education. It is a reciprocal and actual relationship that deserves the attention of every physician in Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with highest commendation with an amendment to the third sentence of the first paragraph, under **RECOMMENDATIONS** to read as follows:

"The Board should consist of two representatives of the Georgia Society of Otolaryngology and two representatives of the Society of Ophthalmology, one representative from each of the two medical schools, two representatives of the Medical Association of Georgia, at least one of whom will be a member of the School Child Health Committee, and a representative of the Medical Advisory Committee of the Georgia Society for Prevention of Blindness."

HOUSE OF DELEGATES ACTION—Adopted the report with the change recommended by the Reference Committee.

Resolution 70-3

Medical System for Mass Casualty Situations

DeKALB COUNTY MEDICAL SOCIETY

WHEREAS, our present society tends to collect and move people in large groups allowing a potential for occurrence of mass casualty situations, i.e., one which overloads the existing medical facilities; and

WHEREAS, there does not exist in Georgia at present an adequate system for supplying medical assistance supplies to an overloaded facility or area,

THEREFORE BE IT RESOLVED, that a standing committee or subcommittee be established in the MAG to create an effective medical system to assist in mass casualty situations and that the system be reviewed semi-annually; and

BE IT FURTHER RESOLVED, that a mass casualty management manual be prepared and made available to such treatment centers as would be recipients of mass casualties.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation, with amendment to the first RESOLVED to read as follows:

“THEREFORE BE IT RESOLVED, that the MAG Committee on Emergency Medical Services create new programs and coordinate existing programs to produce an effective medical system to assist in mass casualty situations and that the system be reviewed semiannually.”

HOUSE OF DELEGATES ACTION—Adopted the Resolution with the change as recommended by the Reference Committee.

Resolution 70-6

Availability and Abuse of Amphetamines and Other So-called Appetite Suppressants

HALL COUNTY MEDICAL SOCIETY

WHEREAS, there is an alarming drug problem throughout the state of Georgia, as well as throughout our entire country; and

WHEREAS, the medical profession has such a profound interest in, and knowledge of, this problem; and

WHEREAS, there is actually such a very limited use or even questionable need for these particular drugs in the practice of good medicine; and

WHEREAS, the easy accessibility and abuse of the use of these drugs has had such a detrimental effect upon a broad segment of our society;

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia strongly recommend that the sale of all amphetamines and related drugs that are referred to as appetite suppressants be controlled in the state of Georgia by the same regulations which apply to Class A narcotics.

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the Speaker of the House of Delegates of the American Medical Association with the firm recommendation that they consider passing a similar resolution to be applied nationwide.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends disapproval of the resolution in its present form but recommends the resolution be referred to the Council for further study and necessary action.

HOUSE OF DELEGATES ACTION—Rejected the resolution and referred it to Council for further study and necessary action as recommended by the Reference Committee.



James W. Harkess, M.D., Louisville, Ky., participant in the panel discussion, “Government and Medicine.”

Resolution 70-7

Commendation to Kiwanis Clubs of Georgia for Activities in Drug Abuse

MAG COUNCIL

WHEREAS, the Kiwanis Clubs of Georgia have demonstrated an active concern in Drug Abuse insofar as health problems arise; and

WHEREAS, there has been a growing number of drug addiction cases causing a greater need for activity in this area; and

WHEREAS, the Kiwanis Clubs of Georgia have presented educational programs on Drug Abuse, further preventing the spread,

THEREFORE BE IT RESOLVED, that the MAG Council expresses appreciation to the Kiwanis Clubs of Georgia for the invaluable services they have rendered to the public and to the profession by their activities; and

BE IT FURTHER RESOLVED, that a copy of this resolution be sent to the Governor of the Georgia District of Kiwanis International.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-8

Commendation to Georgia Junior Chamber of Commerce for Activity in Emergency Medical Services

MAG COUNCIL

WHEREAS, the Georgia Junior Chamber of Commerce has demonstrated an active concern for the public; and

WHEREAS, the Georgia Jaycees have continually taken on projects for the benefit of continued health improvement; and

WHEREAS, the Georgia Jaycees are taking on a project on Emergency Medical Services which will be conducted on a state and national level,

THEREFORE BE IT RESOLVED, that the MAG Council commends the Georgia Jaycees for their efforts in endorsing Emergency Medical Services activities; and

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the President of the Georgia Jaycees and to the National President of the Jaycees.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-9

Commendation to Lions Clubs of Georgia for Leadership in Foundation for the Blind

MAG COUNCIL

WHEREAS, the Lions Clubs of Georgia are continually conducting projects to further their assistance to the blind,

THEREFORE BE IT RESOLVED, that the Council of the MAG expresses its appreciation to the Lions Clubs of Georgia for the invaluable services it has rendered to the public; and

BE IT FURTHER RESOLVED, that a copy of this resolution should be sent to the President of the Lions Clubs of Georgia.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval with commendation.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Resolution 70-12

Endorsement of Traffic Safety Legislation

FULTON COUNTY MEDICAL SOCIETY DELEGATE

WHEREAS, there is a need for improving the transportation of the injured as well as identifying drivers with medical handicaps compromising their driving abilities; therefore be it

RESOLVED, that the Medical Association of Georgia

by the action of this House of Delegates go on record in support of and encouraging the General Assembly of Georgia in the passage of legislation on the ambulance service statute, Medical Advisory Committee, and a meaningful re-examination for driver's license.

REFERENCE COMMITTEE RECOMMENDATION
—Your Reference Committee recommends approval of this resolution with commendation.

HOUSE OF DELEGATES ACTION—Adopted the resolution as recommended by the Reference Committee.

Chairman Wilson then stated that this concluded the report of Reference Committee E and that he wished to thank the members of the Reference Committee for their time and effort. Chairman Wilson moved the adoption of the Report of Reference Committee E as a whole. The motion was duly seconded and adopted.

Speaker Rogers then called for Unfinished Business, and there being none, Dr. Rogers opened the floor for New Business, advising the House that New Business would be received for information only as no action could be taken by the House except on business of an emergency nature which would require a unanimous vote for introduction.

The following resolution was then introduced for information only:

Resolution

WHEREAS, the Medical Association of Georgia in its Annual Meeting, May 1970, recognizes the potential for saving life in the emergency techniques of cardiopulmonary resuscitation (CPR), and

WHEREAS, the extension of training in CPR to physicians, nurses and paramedical personnel of the hospitals of Georgia, as a project of the Georgia Heart Association in conjunction with the Georgia Regional Medical Program, has been of proven worth in the saving of lives throughout the state and

WHEREAS, such training has now involved over 4,000 citizens of Georgia and has been incorporated as in-service training in many of the hospitals of this state, therefore

BE IT RESOLVED, that the Medical Association of Georgia does, in fact, endorse those voluntary efforts of the growing cadre of physicians, nurses and others who have received instruction in CPR technique, many of whom are now actively rendering service to their hospitals by instructing others in this vital emergency procedure and

BE IT FURTHER RESOLVED, that this body approves, recommends and encourages training in CPR for every practicing physician in this state and for the nurses, paramedical and emergency personnel as a life-saving measure of outstanding value to the people of the state of Georgia.

There being no further New Business, Speaker Rogers then thanked every member of the Reference Committees for their diligent work and the entire MAG office staff for their assistance, and enter-

tained a motion for the Adjournment of the Second Session of the MAG House of Delegates meeting in conjunction with the 116th Annual Session of the Medical Association of Georgia. On motion duly

made and seconded, the House was adjourned and the meeting turned back over to President Train for the continuation of the Third General Session of the MAG General Session.

MAG Third General Session (Reconvened)

116th Annual Session of the Medical Association of Georgia

Sunday, May 10, 1970

PRESIDENT TRAIN then reconvened the Third General Session of the 116th Annual Session of the Medical Association of Georgia and expressed appreciation to Drs. Harrison L. Rogers and Preston D. Ellington for their efficient manner in presiding over the 1970 House of Delegates.

President Train then called for a Commercial Exhibit attendance card to be drawn, and then announced the winner, Dr. Joseph L. Mulherin, of Augusta. Dr. Mulherin was presented with a portable television set as the exhibit attendance prize.

Installation of Officers

President Train then asked the Incoming President, the Officers, the AMA Delegates and Alternates, the Councilors and Vice Councilors to please stand at their seats for the installation of Officers as follows:

President—F. G. Eldridge, Valdosta (1971)
President-Elect—W. C. Mitchell, Smyrna (1971)
Immediate Past President—John Kirk Train, Jr. (1973)
First Vice President—F. William Dowda, Atlanta (1971)
Second Vice President—Henry D. Scoggins, Augusta (1971)
First District Councilor—C. E. Bohler, Brooklet (1973)
First District Vice Councilor—J. Roy Rowland, Jr., Dublin (1973)
Second District Councilor—J. D. Bateman, Albany (1973)
Second District Vice Councilor—Donald J. McKenzie, Thomasville (1973)
Third District Councilor—J. T. Christmas, Vienna (1973)
Third District Vice Councilor—John H. Robinson, Americus (1973)
Fulton County Councilor—J. Harold Harrison, Atlanta (1973)

Fulton County Vice Councilor—William W. Moore, Atlanta (1973)

Georgia Medical Society Councilor—L. R. Lanier, Jr., Savannah (1973)

Georgia Medical Society Vice Councilor—L. S. Bodziner, Savannah (1973)

Eighth District Councilor—Robert E. Perry, Jr., Brunswick (1971)

Eighth District Vice Councilor—Joe C. Stubbs, Valdosta (1971)

AMA Delegate—J. Frank Walker, Atlanta (December 31, 1972)

AMA Delegate—Preston D. Ellington, Augusta (December 31, 1972)

AMA Alternate Delegate—J. D. Bateman, Albany (December 31, 1972)

AMA Alternate Delegate—F. W. Dowda, Atlanta (December 31, 1972)

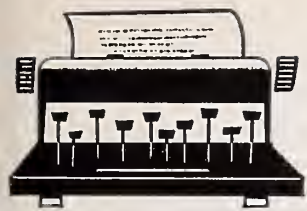
President Train declared each of these new officers duly installed and turned the gavel of leadership over to Incoming President F. G. Eldridge, who expressed his appreciation to the membership for the honor of being selected President and the trust placed in him.

President Eldridge then presented to Outgoing President Train the President's Key and a bound volume containing the issues of the *Journal of the Medical Association of Georgia* published during Dr. Train's term as President.

President Eldridge then announced that the official attendance at the 116th Annual Session of the Medical Association of Georgia held in Jekyll Island, Georgia, May 7-10, 1970 was as follows:

MAG Members—612; Guests—195; Exhibitors—89; Auxiliary—265; thereby making a grand total of 1,161 registered.

There being no further business, President Eldridge adjourned the 116th Annual Session of the Medical Association of Georgia at 12:15 p.m.



W. C. Mitchell of Smyrna Installed as President-Elect

WILLIAM CLAUDE MITCHELL, General Practitioner from Smyrna, Ga., was installed as President-Elect of the Medical Association of Georgia at the Association's 116th Annual Session on Jekyll Island, May 7-10.

Dr. Mitchell, born in Atlanta, Ga., received his B.S. degree from Emory University and his M.D. degree from the Emory University School of Medicine, in 1931. He did his internship and residency at Grady Memorial Hospital in Atlanta from 1931 to 1933 and then began his practice of medicine in Smyrna.

Dr. Mitchell is a charter member and past president of the Smyrna Kiwanis Club, has served as chairman of the Cobb County Board of Education for over 10 years and on the Cobb County Board of Health for over 15 years, serving much of that time as chairman of the Board. He has served on the Smyrna Library Board, as a director on the Cobb County Chamber of Commerce and as first president of the Smyrna Chamber of Commerce. Dr. Mitchell is a charter member and past president of the Smyrna Men's Club, is active in Boy Scout and Masonic work, and is director of two banks.

He is a member and past president of the Seventh District Medical Society, Cobb County Medical Society, and has been a delegate to the Medical Association of Georgia for several years. He has served on the Advisory Board to the Women's Auxiliary of MAG, as vice-counselor to MAG from the Seventh District Medical Society, and presently serves as counselor from the Cobb County Medical Society. He is also a member of GaMPAC and the American Academy of General Practice.

Dr. Mitchell is married to the former Mildred Bell Valentine.

Pitfalls in the Catheterization of the Snake

THE AZALEAS OF SAVANNAH are spent. Dogwoods are again green and the Masters Golf Tournament is history.

As one tours the state, improved ambulance services in Stephens County and Hart County are available. Two-way communication is offered. Trained personnel are manning the units.

Choice roses recommended for small spots of half day sun include First Prize (only All American award), Smokey, and Day Dream—Laura and Pharoah set well together for floribundas. Dalton and Marietta afford full time emergency clinic physicians. These hospitals join the Medical Center of Columbus, Georgia Baptist in Atlanta, and DeKalb General in Decatur in providing such service. A helipad is in the planning stage at Columbus which will provide services known to Savannah and adjacent Armed Forces Bases. How far in the future will such service be found covering our state?

The snake is an interesting specimen. Are not there many similarities in the snake's and man's capabilities and responses? Some are good and some are bad. I would like a letter from any reader who has attempted to catheterize this reptile.

Perhaps no other area of the hospital receives more complaints than does the Emergency Clinic area. Why? Webster defines emergency as (1) "an unforeseen combination of circumstances or the resulting state that calls for immediate action" and (2) "a pressing need."

Delay in providing service is a more frequent issue as well as the medical problem which indeed in the eyes of the physician or nurse is not a "true emergency," thusly overtaxing the available facility.

Why is not the emergency medical service as much a responsibility of the community served as is that same community's fire and police services? No longer can it be looked upon as a secondary service for educating future doctors or being a training service area for the young intern without skillful and knowledgeable supervision at all times. Still at this time the community and most hospital authorities are not willing to support such services financially.

The tide is turning, however. In the year 1970, the counties of Burke, Emanuel, Worth, Floyd, Jenkins and Carlton are joining cities of Monroe and Bainbridge in improving their emergency medical services including appropriate ambulance services with trained attendants. These services have two-way hospital communication to their ambulances. These services join those of Atlanta's Grady hospital and Athens General hospital.

But, let us be back to the snake and its problem. The snake is being seen more frequently these days. Study the coloring of the snake to know if same is poisonous before handling. Catheterizing is safer in the non-poisonous type. Check your emergency clinic or physician's office to be sure anti-venom measures are available before attempting such procedures.

Avoid the highways as a laboratory for snake catheterizing as we still have an abundance of drunken drivers who would not know your plight. Likewise, some of the drivers do not have sufficient vision to differentiate the snake from the man.

Pitfalls—yes! Good luck on your endeavors and please: BE CAREFUL.

*Fleming L. Jolley, M.D., Atlanta
Immediate Past Chairman, Emergency Medical
Services Committee*

Highlights of the 1970 MAG Annual Session

THE 116TH ANNUAL SESSION of the Medical Association of Georgia was convened on Jekyll Island on May 7-10. Many refinements were made in the general format of the meeting, which gave an air of informality to the 1970 gathering.

Registration exceeded 1,000, and representation from all parts of the state at the meeting generally and in the House of Delegates was very apparent.

A full scientific program was offered throughout the four-day meeting. Two programs of general interest that cut across specialty lines were presented by MAG and were well attended. These were "Government and Medicine," a panel discussion featuring Mr. James J. Kilpatrick, nationally syndicated newspaper columnist and frequent panelist on "Meet the Press." The second general interest program, "Man, Moon and Medicine," was also a panel presentation which included re-

marks by Dr. Charles A. Berry, Director of Medical Research and Operations for the NASA program.

Meeting in conjunction with the Annual Session was the MAG House of Delegates. Reports and resolutions presented to the House covered a variety of topics. The remainder of these Highlights cover many of these reports and resolutions. A detailed accounting of each proposal presented to the House, the subsequent recommendation of the Reference Committees and the final action taken by the House appears elsewhere in this issue of the *Journal*.

Abortion

Two Committee reports and one resolution dealing with various aspects of therapeutic abortion were merged by the House in its consideration of the MAG position on this subject. The House voted to authorize a mass survey of the MAG membership and then voted to refer to Council the matter of making a determination as to the MAG position concerning probable abortion legislation during the 1971 session of the General Assembly.

Sterilization

In adopting a resolution from the Crawford W. Long Medical Society, the House voted to place MAG on record in favor of extending Medicaid payments to cover the cost of voluntary sterilizations.

1969 Additional Dues

On the matter of the \$100 additional dues, adopted by the 1969 House of Delegates, the House voted to extend the deadline for receipt of these dues until December 31, 1970 and included in that same action that those from whom the additional dues had not been received would stand suspended from membership as of that date.

Health Planner

The House and its Reference Committees considered several reports dealing with the employment of additional staff personnel. Included among these was a Supplemental Report of Council which called for the hiring of a Health Planner. The function of the Health Planner would be to coordinate many of the current health programs, find ways to attract government and foundation grants, write up health projects for state-level implementation, and to assist local groups in planning various health projects. Under the terms of the House action, said Health Planner would be expected to attract grants, etc., with which to offset the expense of his salary and that of his staff.

SAMA

The House voted to extend ex-officio membership in the House of Delegates to members of the Student American Medical Association on the basis of one annually elected Delegate from each SAMA chapter in Georgia.

Constitution and Bylaws

The House adopted numerous technical amendments to the Bylaws, designed to keep the document updated and useful to the operation of the Association. It also adopted two Constitutional amendments which had been "on the table" since the 1969 meeting. Among the changes made were:

—Increased from 20 Delegates to one-third of the membership of the House the number of Delegates required to call special meetings.

—Established Council as the final arbiter of dues-exempt status of members.

—Replaced "Roberts' Rules of Order" with "Sturgis Standard Code of Parlia-

mentary Procedure" as the code for the conduct of business before the House of Delegates.

—Made more flexible the meeting dates of Council.

Legislation

In adopting the report of the Committee on National Legislation, the House voted its endorsement of the AMA "Medicredit" plan which is the AMA alternative to the numerous national health insurance plans currently being offered.

The "Medicredit" plan is based on a system of federal income tax incentives through which individual and family taxpayers would be encouraged to obtain adequate health insurance protection. The amount of tax credit granted an individual or family would be in proportion to the amount paid in federal income taxes. Those in low income groups with little or no tax liability would, under the "Medicredit" proposal, receive "medical care vouchers" which could be used to purchase qualified health coverage from private insurance companies or prepayment plans.

In adopting the report of the Committee on State Legislation, the House gave its approval to a public information program to reveal the nature of chiropractic in Georgia.

Proficiency Testing in Physician's Laboratories

The House adopted a resolution endorsing the principle of voluntary proficiency testing in physician's laboratories and urged the MAG Committee on Medical Review and Negotiating to develop, without delay, guidelines for this purpose.

Serological Test for Syphilis

A Walker-Catoosa-Dade County Medical Society resolution calling for the repeal of state laws on serological testing for syphilis as a requirement for obtaining a marriage license was received by the House and referred to Council for additional study and possible action.

GaMPAC

The House reaffirmed its endorsement of GaMPAC without a dissenting vote and urges all physicians to actively support PAC in Georgia.

Comprehensive Prepaid Medical Insurance

In adopting the report of the Committee on Insurance and Economics the House voted to authorize the appointment of a study committee to report to the I. and E. Committee on the feasibility of establishing an MAG-sponsored comprehensive prepaid medical insurance program.

Medical Review and Negotiating

In considering the report of the Committee on Medical Review and Negotiating, the House adopted the following:

—Encouraged physicians to adopt for their own use the 1970 AMA Current Procedural Terminology, containing 5-digit coding and nomenclature for all claims submitted, and also urged third parties to accept the 1970 CPT as the basis for receipt of all claims.

—Authorized the employment of a lay coordinator for Peer Review, together with supportive staff at such time as Medicaid reimbursement becomes available with which to fund this project.

—Expand the scope of responsibility of the Medical Review and Negotiating Committee to include all matters regarding Peer Review, including certification of

“usual, customary and reasonable” fees, utilization of manpower, medications and appropriateness of care rendered.

Workmen's Compensation

The House approved a resolution endorsing “usual and customary” fees under the Workmen's Compensation program and urged the Compensation Board to cooperate with MAG in adopting forms and code schedules that do not make unusual demands on the secretarial and clerical help in physicians' offices.

Medicaid Fraud Disclaimers

The House approved a resolution which declared that members of MAG will sign fraud disclaimers on Medicaid claim forms only under protest and that MAG should pursue a course of action calculated to have such disclaimer statements stricken from future Medicaid forms.

Mass Casualty Medical System

In adopting a resolution from the DeKalb County Medical Society, the House called on the MAG Committee on Emergency Medical Services to create new programs and coordinate existing programs to produce an effective medical system to assist in mass casualty situations. It also authorized the preparation of a mass casualty management manual that would be available to mass casualty treatment centers.

Pre-School Age Vision and Hearing Screen

In adopting the report of the Committee on School Child Health, the House authorized the appointment of a Board of Trustees to serve as the governing body for a program to screen all preschool age children for possible vision and hearing defects. As contemplated by the report, this effort would involve numerous lay organizations and health oriented groups outside the Medical Association of Georgia.

Drug Abuse

The House voted to refer to Council a resolution aimed at curbing the flow of amphetamines and related drugs by having the regulations that apply to Class A narcotics apply also to amphetamines and other so-called appetite suppressants.

Lay Organizations Commended

The House adopted several resolutions commending the work of lay organizations in Georgia. These were: the Kiwanis Clubs of Georgia for their programs on drug abuse; the Junior Chamber of Commerce for their project on Emergency Medical Services, and the Lions Clubs of Georgia for their programs of assistance to the Blind.

Awards Presented

Thomas W. Goodwin, M.D., Augusta, was presented the Distinguished Service Award; Walter E. Brown, M.D., Savannah, was elected the General Practitioner of the Year; Beverly W. Forester, M.D., Macon, was given the Hardman Certificate; Noah D. Meadows, M.D., Marietta, was presented with the Civic Endeavor Award; Zuher M. Naib, M.D., Andre J. Nahmias, M.D. and William E. Josey, M.D., all of Atlanta, took first place in the Scientific Exhibit Awards for their exhibit, “Genital Herpetic Infection and Cervical Cancer.” Three GaMPAC awards were presented—two for the highest percentage of membership, which went to Upson County and the Fourth District, and a third for the largest financial contribution to GaMPAC, which went to the physicians and their wives in DeKalb County.



JEKYLL ISLAND—1970

LAST YEAR JOHN KIRK TRAIN was inaugurated in Savannah. This was most appropriate, because Kirk was “at home” among relatives, friends, and colleagues. It was also appropriate that I was inaugurated in my own Eighth District, and on the shores of Jekyll Island—a beautiful island so wisely purchased by a close personal friend, Governor M. E. Thompson, during his all-too-short tenure in the service of this state.

To say that the Glynn County Medical Society performed an exemplary job is surely an understatement! The setting was gorgeous, with flowers in full bloom and weather which was “just what the doctor ordered.” The lovely setting with perfect weather was conducive to outdoor activities but not, I fear, so conducive to the myriad “indoor” requirements necessary to accomplish the work of the Medical Association. Air conditioning is great, and I suppose it’s good that windows are unnecessary, or nothing would be accomplished with the working members looking outside!

One of the privileges and pleasures of being President is receiving an invitation to address the ladies of the Auxiliary and see them in action. Their potential is unlimited. We should not only support them, but request them to aid us in our projects.

Accolades for Preston Ellington and his Annual Sessions Committee for a superb new format for our Annual Sessions are in order, as well as for the well-designed programs and the wonderful entertainment. Of course, with a change in time and days of the week, a certain amount of rearranging must be done by various specialty societies and other groups to meet their own individual needs, but compromises will more than likely take place and these conflicts be erased.

Some minor disruptions are ever present when meeting in any location selected, such as arranging for the exact type of accommodations desired, coordinating plane schedules, coping with drawbridges and separation of individuals and groups in different motels, etc. I fear doctors are like patients in many ways—“We want what we want when we want it!” There was ample time for fun in the sun on the beaches, and for golf, swimming, tennis, and other outdoor sports. It goes without saying that Brunswick and its environs have very little competition when speaking of food.

The work and purpose of Association business was carried out with dispatch, and, due to the excellent preparation by the MAG Headquarters staff personnel, the functions of the Executive Committee, Council, General Session and House of Delegates meetings were transacted efficiently and expeditiously. Incidentally, if I had only one wish regarding the business of medicine, it would be that each physician in the state of Georgia could and would attend a meeting of the House of Delegates of MAG, or at least visit a meeting of the Council of MAG to see what is being accomplished for medicine in general and the practicing physician in

Georgia in particular. Surely, there would never be occasion for the question, "What does MAG do for me?" if such attendance, or visit, was made.

If all this sounds like I am somewhat prejudiced in favor of the Medical Association and admire the people who make the Association possible, my intentions are just that. One word can sum up my opinion of each and every one of these persons who contribute their time, abilities, energy and own money—just TREMENDOUS!



F. G. Eldridge, M.D.
President, Medical Association of Georgia

The heart in itself is not the beginning of life; but it is a vessel formed of thick muscle, vivified and nourished by the artery and vein as are the other muscles.

—Leonardo da Vinci

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SOCIETIES

The **Bibb County Medical Society** will furnish first aid kits to the various Little Leagues in Macon this year. Charles L. Ridley, Jr., is in charge of the project.

The **Georgia Medical Society** has endorsed Chatham County's all-out attack on venereal disease. The county's program is designed to "run down" all contacts of known syphilitics, even to the point of locating latent syphilis in persons not knowing they have the disease.

PERSONALS

First District

Irving Victor departed April 28 for a two-month tour in South Vietnam as a visiting professor of urology at the University of Saigon.

Second District

Fred L. Nelson has been installed as president of the Second District Medical Society. Other officers are as follows: **T. Gray Fountain**, vice president; **W. P. Stoner**, secretary-treasurer; **John D. Bateman**, Councilor, and **Donald J. McKenzie**, Vice Councilor.

Third District

J. R. Arnall has been elected to active membership in the American Academy of General Practice.

Fifth District

Albert Lee Morris has been re-elected to active membership in the American Academy of General Practice.

Lea Richmond has been reappointed to a four-year term on the Hospital Authority of Fulton County.

Albert A. Rayle has been named Chairman of the Board of United Physicians Service, Inc. (Blue Shield).

Tenth District

Fred M. Bell, Atlanta surgeon, will open offices in Madison for two days a week.

DEATHS

Robert Drane

Robert Drane, believed to have been Georgia's oldest radiologist, died April 11 at the Oglethorpe Sanatorium in Savannah. He was 82.

Dr. Drane, a native of Edenton, N.C., moved to Savannah in 1919 and opened a private office there in 1920. He retired in July, 1967, because of ill health.

He had served on the medical staff of the Oglethorpe Sanatorium, St. Joseph's Hospital, the Georgia Infirmary, Telfair Hospital, Central of Georgia Hospital, Memorial Hospital and the U.S. Marine Hospital.

He was a charter member of the Georgia Radiological Society and served as its second president. He was a past president of the Georgia Medical Society.

Dr. Drane was a Fellow of the American College of Radiology and a member of the American Medical Association, Southern Medical Association, Medical Association of Georgia and the Radiological Society of

North America. He was a past chairman of the American Roentgen Ray Society finance committee.

He was a member of Christ Episcopal Church. He was a member of the Benevolent Society, Order of Colonial Wars, Oglethorpe Club, Cotillion Club, Forrest City Gun Club and the Savannah Golf Club.

A 1910 Graduate of the University of North Carolina, he received his M.D. degree from the University of Pennsylvania in 1913. He served his internship at Protestant Episcopal Hospital in Philadelphia, Pa. Dr. Drane was also instructor of clinical medicine at the University of Wisconsin from 1915 to 1917.

He is survived by his widow, Mrs. Naomi Everett Drane; two sons, Robert Brent Drane of Savannah and Jack Albert Gore of Falls Church, Va.; a sister, Mrs. J. C. Webb of Hillsborough, N.C.; a brother, the Rev. Fred B. Drane of Edenton, N.C.; and several nieces and nephews.

Stephen E. Furst

Stephen Edward Furst died April 9 in Atlanta of a heart attack. He was 36.

Dr. Furst, an internist and cardiologist in Atlanta for eight years and a member of the Emory University faculty, was a native of Bessemer, Ala., and was a graduate of Harvard University and the University of Pennsylvania Medical School.

He was also a member of the staffs of St. Joseph's and Crawford W. Long hospitals and the Jewish Home for the Aged.

Dr. Furst is survived by his widow, a daughter and his mother.

W. A. Selman

William Arthur Selman, 95, the longest practicing physician and surgeon on the Fulton County Medical Society roster, died April 13 in a private hospital.

Dr. Selman was graduated from the University of Georgia in 1897 and received his M.D. degree from the Atlanta College of Physicians and Surgeons, later Emory University, in 1902. He interned at Grady Memorial Hospital in Atlanta.

During World War II, Dr. Selman was Georgia chairman for Physicians and Procurement and Assignment

Services and received a certificate of commendation from President Harry Truman for his service.

He had been a Fellow in the American College of Surgeons since 1920 and was past president of the Fulton County Medical Society and the Medical Association of Georgia. He also was an associate professor of surgery at Emory Medical School for many years.

Dr. Selman was a Shriner and a member of the Second Ponce de Leon Baptist Church, Phi Chi fraternity, the Atlanta Athletic Club and Druid Hills Golf Club.

He is survived by two daughters.

Thomas M. Ezzard

Thomas M. Ezzard, a Roswell physician for 50 years, died at his home April 26. He was 87 years of age.

Dr. Ezzard was a 1913 graduate of the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine. He was a member of the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association and Roswell Lodge 165, F&AM. He was an honorary steward of the Roswell Methodist Church.

He is survived by his widow, two daughters and a son.

Marcus L. Webb

Marcus L. Webb of Tifton died March 28 at Tift General Hospital after a long illness. He was 86 years of age.

A native of Berrien County, he was a graduate of Atlanta Medical College and practiced in Georgia and North Carolina through 1968.

He was the oldest medical doctor in Tift County, and had lived there since 1935. He was a member of the American Medical Association, a veteran of World War I, member of the World War I Barracks, Tifton Elks Lodge, Tifton Masonic Lodge No. 47, F&AM, Hasan Shrine Temple and Order of the Eastern Star.

Survivors include five brothers, T. J. Webb, Lake Placid, Fla.; Homer Webb, Miami Beach, Fla.; M. B. Webb, Omega; L. H. Webb, Ray City and H. W. Webb, Valdosta, and several nieces and nephews.

T. MARK HODGES NAMED ASSOCIATE LIBRARIAN FOR SOUTHEASTERN REGIONAL MEDICAL LIBRARY PROGRAM

T. Mark Hodges has joined the staff of the A. W. Calhoun Medical Library of Emory University as associate librarian for the Southeastern Regional Medical Library Program.

Mr. Hodges came to Emory from the Harvard Medical School in Boston where he was in charge of the New England Regional Medical Library Service at The Francis A. Countway Library of Medicine.

In his new role Mr. Hodges will be in charge of the newly operative Southeastern Regional Medical Library Program serving the states of Alabama, Florida, Georgia, Mississippi, South Carolina and Tennessee, and the Commonwealth of Puerto Rico.

Financed by the Public Health Service through the

National Library of Medicine, the program will provide such services as document delivery (either by loan of original material or by copy); a reference service; MEDLARS Searches (MEDLARS means Medical Literature Analysis and Retrieval System); consultation and advice on library problems; and education in health science librarianship.

Funding for the nationwide regional medical library network is authorized by the Medical Library Assistance Act of 1965.

The success of the program will depend largely on the cooperation and availability of resources of the 12 medical school libraries in the region, Mr. Hodges said.

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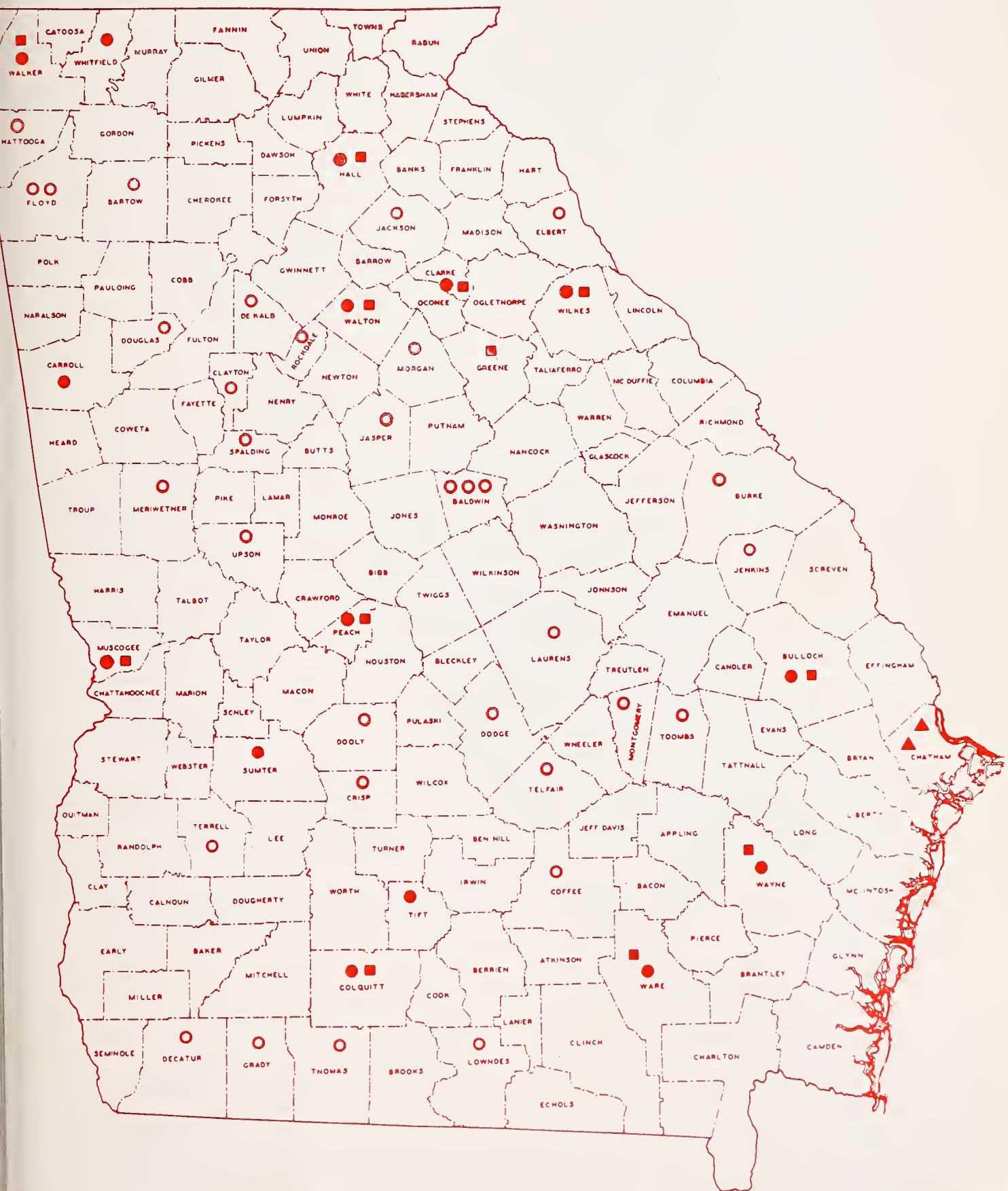
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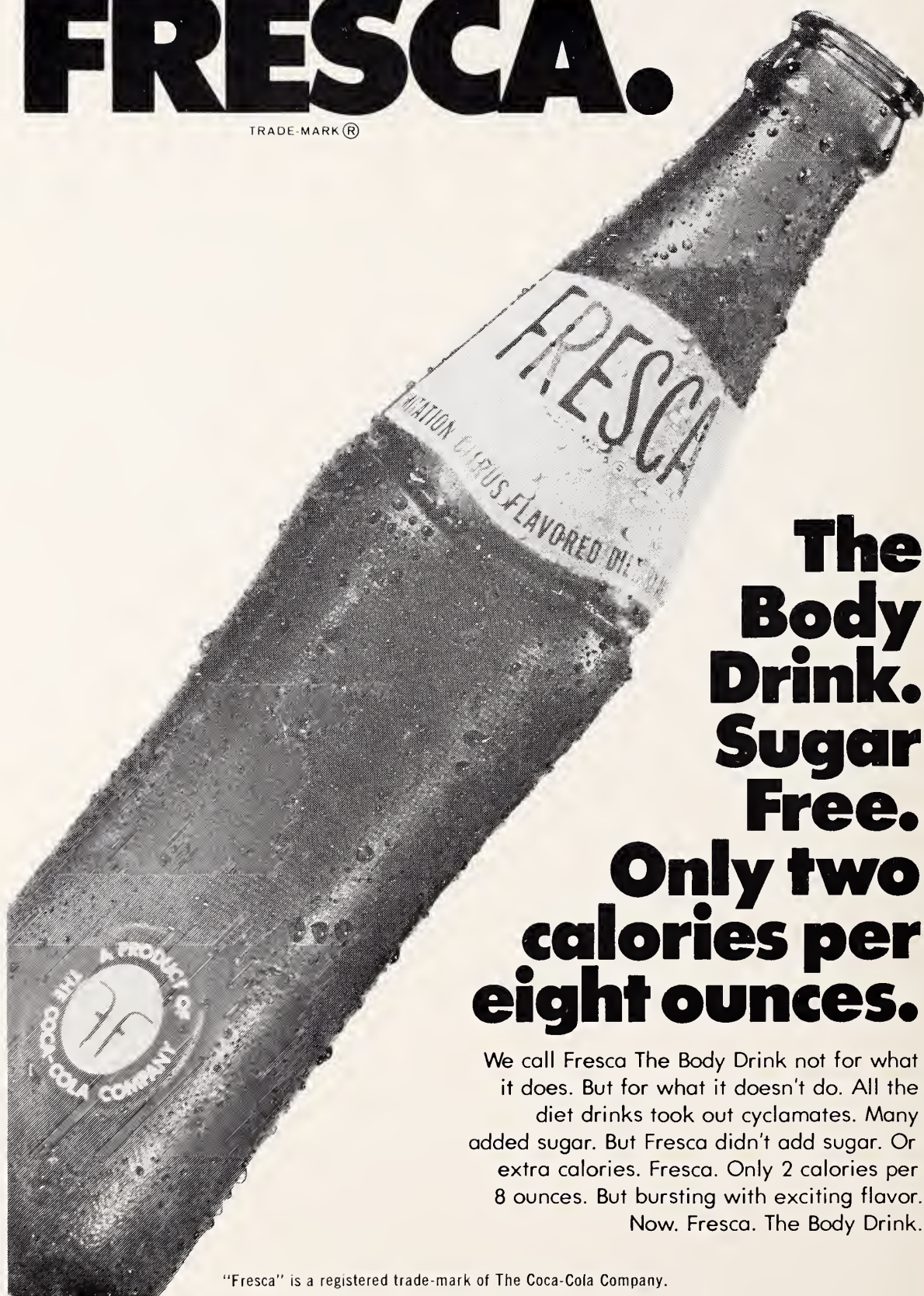
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Contents

Scientific Articles

RECOGNITION OF THE NATIONAL NEED FOR EDUCATION OF PHYSICIANS IN FAMILY PRACTICE William R. Willard, M.D.	277
INTENSIVE CORONARY CARE IN A 42-BED RURAL HOSPITAL Alan G. Bartel, M.D., and Curtis G. Hames, M.D.	284
INJURY TO THE KIDNEY AND URINARY BLADDER IN BLUNT ABDOMINAL TRAUMA Donald J. McKenzie, M.D., F.A.C.S.	290
MALARIA IN GEORGIA Julian Jacobs, M.D.	292

Special Article

DISASTER PREPAREDNESS IN GEORGIA Virgil B. Williams, M.D.	282
--	-----

Editorials

THERMAL BURNS Pat C. Shea, Jr., M.D.	294
COMMITTEE CONCLAVE	296

Features

President's Letter	297
Cancer Page	299
Heart Page	301
Legal Page	303
Month in Washington	308

The Association

Abstracts by Georgia Authors	305
New Members	306
Societies	306
Personals	306
Deaths	306

Cover

Design by Marie Seaman.

There is need to look at the problem of delivery of health care from new perspectives; many of our old assumptions must be modified.

Recognition of the National Need for Education of Physicians in Family Practice

WILLIAM R. WILLARD, M.D., *Lexington, Ky.**

THERE IS AMPLE EVIDENCE of public dissatisfaction with our system of medical care. We are living, I believe, in a period of crises created by unsatisfied demands and expectations of our people. We cannot satisfy the demands and expectations of the public merely by providing more of the same—by training more physicians, by building more hospital beds, and by performing more diagnostic and therapeutic procedures. There are fundamental flaws in our present health care delivery system. Services are not uniformly available to all segments of the population and frequently access to health care is most difficult. Examples are numerous; adequate services are not available in the ghettos, many rural areas, and for the disadvantaged generally. Witness the long hours spent by many patients in the waiting rooms of physicians and clinics and the explosive growth in the use of the emergency room. In addition, consider the impersonal character of much of medical practice and the ever-escalating costs of health care. The fragmentation of medical care, the lack of coordination and continuity, the inadequacy of emphasis upon preventive medicine and health maintenance—all of these have been criticized for years by many professional and lay people.

What is called for, clearly, is major improvement in our system of delivery of health services. We must look at the problem of delivery of health care from new perspectives; many of our old assumptions must be modified. There is now a sense of crisis and urgency; we cannot wait for the slow

evolutionary processes of social change. It is against this background that I wish to discuss the national need for education of physicians in family practice.

Balance Between Generalist and Specialist

One of the elements in the solution of this problem is related to the way in which we resolve the general issue of specialization vs. integration. Translated into medical terms, this means the balance between the specialist and the generalist. The desirability, importance, and inevitability of specialization have been demonstrated amply as science has advanced, and this will continue. However, there has not been a concomitant development of the generalist.

The generalist is one who integrates, coordinates, and synthesizes the knowledge and skills of various specialists to meet the medical needs of his patient. Synthesis and integration are difficult to achieve. They require persons with a broad range of knowledge, reasonable familiarity with all the specialty fields involved (although not in the detail or depth required of a specialist), and a capacity to conceptualize and relate knowledge from the several fields to achieve a beneficial answer. To do this requires special skills and attitudes—a point of view that is often different in subtle ways from that of the specialist. These skills, attitudes, and points of view usually can be developed by training; however, we have been so busy discovering new knowledge and teaching specialized skills that we have not been training the generalist. Physicians who have not been trained as generalists have great difficulty in understanding the role and importance of the generalist and what is so unique about him.

* Chairman of the Council on Medical Education of the American Medical Association and Vice-President for the Medical Center at the University of Kentucky, Lexington, Kentucky.
Presented on October 7, 1969, at the Family Practice Symposium at the Medical College of Georgia, Augusta, Georgia.

Examine how we have structured medicine to deal with this issue. There are three kinds of physicians who are considered by some as generalists: the internist, the pediatrician, and the general practitioner. Many of these practice as generalists, but most internist and pediatricians have been trained as subspecialists—the internists more so than the pediatricians. The general practitioner can be called a multi-mini-specialist because he has been trained in several fields, but in each one less than the specialist of that field; and he has no training in the tools and techniques of the generalists. The fact that many internists, pediatricians, general practitioners, and some specialists in other fields function effectively as generalists is not because of their training but in spite of it. This is a valid statement today, although there is evidence that major shifts in our training programs may be under way.

Dr. Leo Simmons, a sociologist who has long been interested in the health field, once said that it is imperative that we spend the same effort and the same amount of resources in synthesizing knowledge and in creating the generalist as we spend in creating new knowledge and the specialist. Only now are we beginning to learn that lesson, and as yet we have not learned it very well. However, much thought and effort are being given to this problem by a number of people. Three approaches now command attention; these are (1) the development of family practice in its new definition, which is quite different from general practice; (2) the multi-specialty group practice; and (3) the physician's assistant, who serves as a primary source of medical care and triage officer with medical supervision and back-up. In my judgment, the most important and promising of these and the most acceptable to the American people and culture is family practice. A significant point is that the modern family physician can be used effectively in a multispecialty group practice or as the supervisor and back-up for a physician's assistant, if, when, and where such a pattern of care develops.

Definition of the Family Physician

You are familiar with the report of the Millis Commission, "The Graduate Education of Physicians,"¹ and with the report of the National Commission on Community Health Services,² and with that of the Ad Hoc Committee of the Council on Medical Education of the American Medical Association, "Meeting the Challenge of Family Practice,"³ all published in 1966. The "primary physician" of the Millis Commission, the "personal physician" of the National Commission on Community Health

Services, and the "family physician" of the Ad Hoc Committee on Education for Family Practice of the AMA's Council on Medical Education—all are one and the same—is considered an essential element in providing comprehensive personal health services.

The family physician, as described by the Ad Hoc Committee, is one who:

"1. Serves as the physician of first contact with the patient and provides a means of entry into the health care system;

"2. Evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care;

"3. Assumes responsibility for the patient's comprehensive and continuous health care and acts as a leader or coordinator of the team that provides health services;

"4. Accepts responsibility for the patient's total health care within the context of his environment, including the community and the family or comparable social unit."

The family physician himself would provide a high percentage of the medical services needed by his patients.

The Association of American Medical Colleges appointed an ad hoc committee to help the Association assume an appropriate posture and role as it deals with the issues raised by these reports. The Committee on Medical Schools and the AAMC in Relation to Training for Family Practice was chaired by Dr. Edmund D. Pellegrino, Director of the Health Sciences Center of State University of New York at Stony Brook. It chose wisely to divorce itself from any previous report and, instead, to address itself to the problem of comprehensive health care and the appropriate role of the medical schools relative to this subject. Its Report⁴ attempted to define the function needed in society for optimal health care. After describing the needs of patients, the Report goes on to say, "The public, in short, is seeking a complex of medical care services with the characteristics of comprehensiveness, continuity, competence, considerateness, and family orientation. This Committee suggests that it is better for medical schools to concentrate on devising a medical care system with these characteristics than to apply any of the particular formulae suggested in the reports which have appeared to date. . . . Within any such system of medical care there is certain to be an increasing need for a general physician of some type. The functions required of this generalist in such a system are diverse." The func-

tions, as described, are similar to those described by the Millis Commission and other reports.

Thus, there is apparent agreement on the part of many thoughtful and influential groups, including a special committee of medical school educators, on the need for a "primary physician," a "personal physician," a "family physician" or, if you prefer the term, a "general physician" who can take the leadership in insuring that the functions enumerated in the Pellegrino Report are discharged. Such a physician will be needed in any system of health care which properly anticipates the future.

Deficits in Current Training

Most training programs in internal medicine and in pediatrics, which are the closest we have to preparation for family practice, are not designed for, nor adequate to prepare, family physicians. With exceptions, these programs prepare their residents to function as consultants and subspecialists rather than as generalists, even though in practice many of them function as generalists. The training programs are usually too narrow in subject matter and scope. Their emphasis is upon the acute patient in the hospital, not upon the ambulatory patient. They are not focused on health maintenance and preventive medicine. These programs are not geared to provide continuity of experience in significant measure and do not enable the resident to see the full social and environmental dimensions of his patient's problems. The programs do not have an adequate community orientation. Of course, there can be and are exceptions to any generalization, but these are the exceptions which tend to prove the rule.

Requirements for Training in Family Practice

Both the Millis Commission and the Ad Hoc Committee on Family Practice have recommended a three-year training program after graduation from medical school, a program designed to prepare a family physician or primary physician—one which would be fully equivalent in scientific rigor to the existing specialty training programs.

There are several requirements which pose major problems to solve before many successful programs for preparing the family physician can be developed:

1. *A suitable model of comprehensive patient care as part of the teaching and research resources of the medical school and the teaching hospital must be developed.*

How can the student understand the role, the satisfaction, and the problems of a family physician when he never sees them exemplified? How

can he be attracted to a career in this field which in his experience is non-existent?

This model, ideally, should provide comprehensive care for a defined population group which represents a cross-section of the community. A population group consisting purely of indigent patients, perhaps a group derived from the ghetto or rural areas, presents many unique and difficult problems and, obviously, is highly relevant to the social problems of today. It has special relevance to some schools. The development of methods of delivering comprehensive health care to the indigent in the ghetto and rural area is worthy of serious study and experimentation. However, for the average school and the average student, this kind of population group is not the ideal one for the preparation of most family physicians. Some schools have attempted to develop models of comprehensive medical care for use in their teaching programs. For the most part, these have been relatively small appendages to the basic medical school program and have not involved significantly, or commanded the commitment of, the major clinical departments and members of their faculties.

Thus, the message given to the students is this: "These examples are interesting, idealistic efforts, but they have little relevance to medicine in the real world." It is true they have little relevance to the real world of medicine as exemplified today, but that world is changing and the medical school programs must change with it.

2. *The appointment of academically-qualified family physicians to the faculties of medical schools is necessary.*

Faculties now are composed of traditional specialists. With a few exceptions, they have no family physicians to develop the model of practice and to provide a role model with whom students can identify. Furthermore, there are few, if any, career opportunities on medical school faculties for family physicians, and the rewards of our schools, i.e., academic promotion and salary, are often geared to traditional, scientific, and clinical research productivity rather than to excellence in teaching and to improving methods of delivery of health services.

There is a potential pool of young physicians who could be attracted to a career opportunity in teaching primary or family medicine and studying problems in the delivery of health care if career opportunities were available.

3. *The creation of a satisfactory organizational framework in the medical school and hospital into which the family physician can fit is necessary.*

If medical schools are to be involved in com-

prehensive medical care, there must be an organizational structure with clearly defined responsibilities and prerogatives and with status and rewards for its faculty comparable to other medical school faculty.

4. *Modification of curricula must be achieved to provide opportunities for students primarily interested in comprehensive health care.*

This involves primarily some additional material related to the social and behavioral sciences, to community medicine, and a clerkship program in comprehensive health care. It is difficult to add another segment of material in an already overcrowded curriculum. However, new medical school curricular patterns are developing which provide multiple tracks so that students can elect their primary areas of interest and have considerable free or elective time. This trend, if continued, will go a long way toward solving the problem. A number of students can elect a track in comprehensive or family medicine and receive adequate preparation. Others can go more traditional and established routes. A further point of relevance in planning the curriculum is the need to look at the periods of undergraduate medical education, internship, and residency training as an integrated whole.

5. *The development of research in patient care and the delivery of health services is essential.*

Faculty charged with developing models of comprehensive health care and with training the family physician should look upon the field of health service delivery as a primary research interest. Such research should be interdisciplinary in character and call upon university disciplines not commonly found upon medical school faculties, such as the social and political sciences, economics, and public administration.

Problems Facing the Family Practice Movement

Many problems will face medical schools and hospitals endeavoring to develop models of comprehensive patient care and to train a family physician. Money is certainly one of them; it seems obvious that, if new responsibilities such as the development of models of health care, the training of family physicians, and research in the delivery of health services are to be added to the existing functions of the medical school, significant additional money will be required. The Council on Medical Education of the American Medical Association, along with other interested persons in government

and the academic world, is giving serious attention to this matter.

Needless to say, there are other problems. The medical profession generally does not yet feel an urgent need for change, but recognition of the need is growing. There will be problems to work out with the profession in each area if a school is to assume responsibility for some defined population group. The problems will vary with each school, but with tact, diplomacy, candor, it should be possible to resolve these problems. The Council on Medical Education of the AMA will try to help, and citizens' planning groups, properly organized and used, can be of immense aid.

Obviously, the process of changing institutional goals, patterns, and organization presents its own unique problems. This will require an involvement of the total teaching staff and the development of an institutional commitment. This may call also for different ways of administration and decision-making than have been developed before.

Interest Among Students

Many people question whether students will be interested in becoming family physicians. The answer appears to be yes, provided their roles can be made truly relevant to the needs of people and society generally. The Student American Medical Association and other groups are far from satisfied with the traditional patterns and conservative approach which the profession and the medical schools have adopted thus far. It is clear that if the role of the primary or family physician is to be popular, it must carry prestige and status commensurate with the rigor of its training program and with other specialties.

As you know, the House of Delegates of the American Medical Association accepted the report of the Ad Hoc Committee on Education for Family Practice and directed the Council on Medical Education to implement its recommendations. It was recognized that implementation would have to be done by the medical schools and the teaching hospitals; however, the Council is stimulating and facilitating the development of new and imaginative programs. As you also know, the American Academy of General Practice accepted the report of the Ad Hoc Committee and is working toward implementation of its recommendations. The major effort so far has been to establish a primary specialty board in family practice. This, however, is just the beginning of the road, not the end. There are only a handful of approved programs that provide appropriate training for family practice as the Ad Hoc Committee conceptualized it.

Understanding Family Practice

Perhaps more discouraging than the paucity of material support is the lack of understanding of what family practice really is. We have so few people who are trained to function as integrators and synthesizers of medical services that few can conceptualize the role and the type of training program required. Most specialists and general practitioners think only in terms of traditional specialization, which is organ system, technique, or age group specialization. They do not appreciate that the family practice program is a specialty of function and that few existing programs prepare a physician for this function or can prepare physicians who can teach this function.

There are other efforts to prepare generalists. The internists are talking about a new approach to training in their field, viz., two years of training in general medicine for the physician who will function as a generalist and two additional years for the subspecialist and consultant. Perhaps this initial two years will be tailored in time to really fit the needs of the generalist. Also, the internists and pediatricians, both of whom have been adaptable and flexible groups in medicine, have tailored a co-operative program. Given time and encouragement, they may create a family physician who can function satisfactorily in today's world. Their specialty boards have status and prestige to help them, whereas the new American Board of Family Practice has the difficult task of earning status and prestige—a task that will take several years at best.

Encouragement can be derived from the approach taken by the American Academy of General Practice in the creation of its specialty board. It has appointed good men to the Board, and it is working cooperatively with other specialty boards and with the National Board of Medical Examiners. We can expect the quality of its work to be excellent.

Finally, the pressures and ferment for change are great. Something new is bound to emerge. It is quite possible that several alternative ways of preparing and recognizing a generalist will emerge and that all of them will be good. Let us encourage all such efforts and not be narrow, possessive, and parochial about one channel.

Summary

In summary, I have discussed the subject of the family physician in the context of our changing society with its increasing demands and expectations for health services and in the light of the growing criticism and concern for the way health care is delivered today. The family physician has a unique

role in the delivery of health services, regardless of the patterns by which health services are organized and delivered. It is not in conflict with, but could be aided by, the development of the physician's assistant and other types of ancillary personnel, and by group practice.

The medical schools must attach importance to the development of models of comprehensive health care in an effort to find new patterns for the delivery of health service, for the training of primary physicians, and for research into the delivery of health services. Within the medical schools and teaching hospitals, an organizational base for family practice and comprehensive health care is needed. Modern trends in the medical school curriculum should make it easier to give selected students an in-depth experience in family practice and comprehensive health care. Financing, attracting students to the field of comprehensive health care, and securing the understanding and energetic support of the medical profession and medical schools are important problems. The new specialty board in family practice should help.

I conclude with a quotation from the Report of Dr. Pellegrino's Committee:⁴

"Clearly, these reports (on the primary, personal, or family physician) challenge the medical schools with a reappraisal of what is at the heart of their existence—improving the health care delivered to our society. In a culture so richly endowed with the scientific and technical apparatus capable of improving the human condition, the medical schools of this country can do nothing less than confront these critical issues directly, creatively, and enthusiastically. . . . The life of the people needs acutely to have the university participate, as the university, in its affairs."

These reports and new developments challenge equally the medical profession.

University of Kentucky

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Disaster Preparedness in Georgia

VIRGIL B. WILLIAMS, M.D., *Griffin*

A SERENDIPITOUS SPIN-OFF from the 1969 hurricane Camille and its devastating path along the Gulf Coast has been an aroused interest in our disaster preparedness in our coastal areas. This interest has been manifested by inquiries as to the location of our preplaced disaster hospitals and supplies. Parallel to this question was one as to how these units are placed in operation.

On these pages it is our desire to furnish answers to the questions posed above. At the same time we urge that those physicians responsible for disaster planning become familiar with this information as applicable to their local communities and possible types of disaster conditions which may be peculiar to their area.

The following is a resume of coastal stored emergency hospital resources from Augusta to Waycross with accompanying capabilities for each:

Waynesboro (Burke), 200 beds, capability 3 days

Millen (Jenkins), 200 beds, capability 30 days

Statesboro (Bulloch), 200 beds, capability 30 days plus 30-day supply HRDI

Lyons (Toombs), 200 beds, capability 30 days

Jesup (Wayne), 200 beds, capability 30 days plus 30-day supply HRDI

Waycross (Ware), 200 beds, capability 3 days plus 30-day supply HRDI

Savannah (Chatham), (2) Natural Disaster Hospitals, 50 beds each, capability 300 patients each.

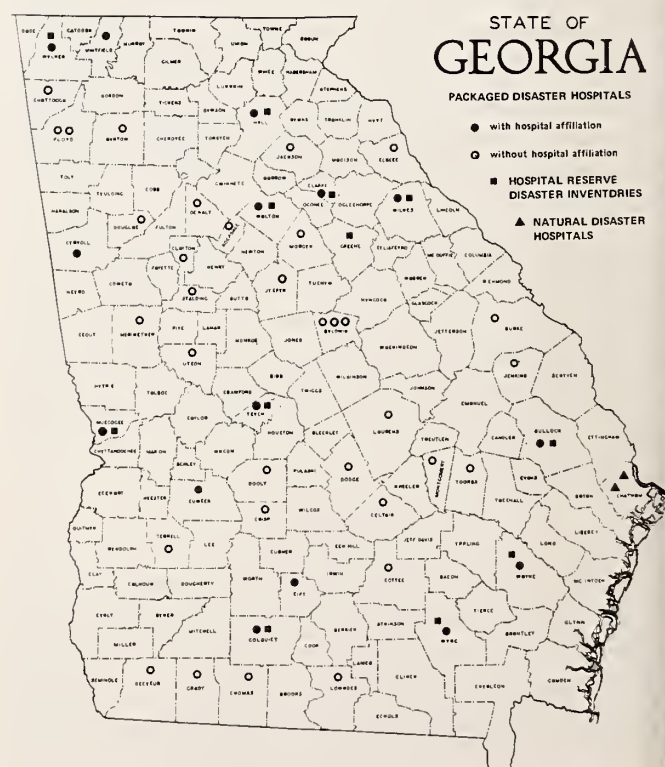
Authorization to operate a Packaged Disaster Hospital at its present location or to transport it to a disaster site may be obtained by contacting either directly, or through State Civil Defense, the State Health Director, Mr. John H. Venable, or Emergency Health Service (Mr. Lyndon Beall or Charles Darden). All custodians and others involved in the upkeep of the Packaged Disaster Hospitals are aware that should this authorization be impossible to obtain due to communications problems or if a time

factor would make it unfeasible (if lives are at stake) they should take the responsibility for opening this equipment and making use of it as they see fit.

HRDI Units

The Hospital Reserve Disaster Inventory units stationed at Statesboro, Jesup, and Waycross are affiliated with the hospitals in those locations and are in daily use to assure that these supplies will be up to date at the time they may be needed. Because of this they are considered to be a part of the operational capability of the hospital to which they are assigned and must actually be accounted for to the administrator of this hospital and not to the State Health Department.

In other words, to obtain auxiliary or disaster supplies from one of these hospitals, one simply contacts the hospital administrator and requests assistance in the form of supplies. The reply to this request would depend entirely on the hospital ad-



ministrator's current stock and willingness to place it at the disposal of those making the request.

The two Natural Disaster Hospitals placed in Savannah are stored under a cooperative arrangement with the Savannah-Chatham Civil Defense Office, and the Chatham County Health Department. The Director of Civil Defense is the custodian and furnishes storage space at the National Guard Armory along with that furnished also at the Memorial Medical Center. The District Health Director, Dr. W. D. Lundquist, is the alternate custodian.

Use During Disaster

The use of one of these units in disaster would be subject to the same regulations and conditions as for the Packaged Disaster Hospital. Upon recognizing the need for one or more of these units, Dr. Lundquist (or the Medical Director of Memorial Medical Center or Medical Director of St. Joseph's Hospital) could place a request either to Mr. Brower, who would contact State Civil Defense, or to Dr.

Venable at the State Health Department, who must give the final authorization. It has also been made clear to all concerned that in the event of communications breakdown or in the event that time would not permit contacting the State Health Department for authorization, the equipment could be put to use and accounted for after the fact. We are certain that they understand that a medical authority should make the final decision and that the Department of Health would certainly condone the use of the equipment when they feel that lives are at stake. The NDH equipment, of course, can be used in conjunction with the hospital to which it is assigned or transported closer to the disaster site for use as a treatment station or sorting and holding facility. Plans are made for both contingencies.

In addition to the local resources, State and Federal assistance could be furnished in the form of medical supplies and equipment, cots and blankets, pesticides, water purification supplies, generators, etc.

571 South Ninth Street

ON HOW TO SURVIVE MEETINGS

Most surgeons are inherently impatient active people with overwhelming needs to do something—anything. The obvious conflict of such a personal pattern with those of a majority of experienced committeemen on medical and community meetings is evident to anyone who has been asked to participate in hospital review boards, bed utilization committees, or a medical alumni advisory group, and the fashionable regional, comprehensive, urban, community, and human relations boards. The increasing number of such meetings requires development of techniques to insure survival without risking brain damage from several clock hours of boredom and adverse physiologic effects of everything stasis.

For example, one may use the inevitable tablet and yellow lead pencil to write an editorial.

Doodling is socially acceptable but, unless one is prepared, it is a limited exercise. The experienced committeeman has taken a few art lessons and spends his time sketching portraits or caricatures of his fellow captives. This is a powerful weapon and can be used to devastate the meeting or a particularly annoying chairman.

Reflective personal notes are difficult to work on in competition with the dissonant babble of voices and, equally disturbing, sudden silences.

Carrying on personal conversations are frowned on, and leaving the meeting at intervals with a colleague may be misinterpreted as reflection of physiologic aging which may be undesirable if one is ambitious to assume leadership.

Of course, one can always instruct one's secretary to call about 15 minutes after the meeting is started, but this ploy can't be used too frequently or the intent becomes obvious.

One can volunteer to pour the inevitable coffee, but unless this is done skillfully it may reflect on one's public image as a surgeon. Surreptitious exercise by tensing various muscle groups is excellent if it is done without involuntary grimaces. Naturally, it is best or wisest to avoid physical contact with adjacent committee members. It can be embarrassing to use a table leg for counter pressure only to find that (1) you have made a mistake of identification, or (2) the furniture is fragile and promptly ruptures.

Sleeping at a meeting is socially unacceptable. Physicians can be immediately identified since they fall asleep immediately after the lights are lowered to show slides. Shading one's eyes or even supporting the chin are suspect. The experienced participant is careful to maintain an uncomfortable position. The talented man nods, orients his head to the speaker, and smiles and votes while sleeping. Some internists have developed this facility as a result of prolonged daily "grand" rounds.

As a last resort, one actively participates in the meeting, especially if a friend is chairman and is desperately trying to stimulate the group. If an abrupt statement in a loud voice has no relevance to the ongoing discussion, one can always follow with a modifier that "he was just testing the water," or "throwing it out for a look-see," or whatever trite phrase is fashionable at the moment. Old phrases, like old jokes, may earn demerits.

Last, always leave the meeting with a show of enthusiasm. Never fail to pick up the materials distributed during the meeting. Always write down the date of the next meeting—after demonstrating that you can't possibly attend on several proposed dates. Compliment your neighbors, the chairman, and leave rapidly as befits a busy man.

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Intensive Coronary Care in a 42-Bed Rural Hospital

"Planned Maximum Personnel Utilization" and "The Coronary Care Assistant"—A Concept to Provide Adequate Personnel

ALAN G. BARTEL, M.D.* and CURTIS G. HAMES, M.D.,† Claxton

THE EFFICACY of the coronary care facility in large urban hospitals has been widely accepted, and a great deal of morbidity and mortality secondary to arrhythmic complications of myocardial infarction has been averted during the past several years. The concept of rapid and aggressive treatment of early and "more benign" arrhythmias in order to forestall the development of more serious disturbances has repeatedly been demonstrated, and has been applied widely in coronary care.¹⁻⁷

In the United States, over 80 per cent of the hospitals have less than 300 beds and lack university affiliation or full time staff.⁸ Several reports of successful C.C.U.'s in community hospitals of 100-300 beds have been published.^{7, 9, 10} In smaller hospitals serving remote or rural areas, therapy of acute myocardial infarction is critical because of the high percentage of arrhythmias occurring within the first few hours of infarction, the inability to select which patients will develop serious arrhythmias, the inadvisability of transporting such patients long distance (i.e.—to an urban area with C.C.U. facilities), and the high cost of C.C.U. operation. It is therefore essential that new methods be developed to afford optimum coronary care to rural areas of our country.

This report summarizes the problems, methods, and results of a two bed C.C.U. in the Evans Memorial Hospital, a 42-bed community hospital started in 1967. The hospital is located in Claxton, Ga. (Evans County), a rural agrarian community of 10,000 people 55 miles from the nearest large hospital and 100 miles from the nearest university hospital.

Personnel and Training Techniques

All of the Coronary Care Unit Staff is derived from the resident population of Evans County. The majority of the nursing training has consisted of an intensive in-service program conducted by the authors. The Coronary Care Nursing Manual of Presbyterian Hospital in Philadelphia, Pa., has provided an excellent source for reading assignments and reference. Audiovisual techniques such as Coronary Care Nursing Training Films (Public Health Service Film Library), models, charts, and diagrams are useful adjuncts to formal training sessions. Several nurses also attended extended coronary care courses for five weeks administered by Georgia Baptist Hospital, Atlanta, Ga. sponsored by the Heart Disease and Stroke Control Program (U.S.P.H.S.). It soon became apparent that the registered nurses selected for the training program made critical an already difficult nursing shortage in the community.

Most qualified and interested registered nurses are so heavily committed to various aspects of health care in the local community that isolation for an eight-hour shift in the coronary care unit created a critical and sometimes dangerous burden in terms of personnel from other health services.

New Care Concept

In an attempt to solve this problem the concept of "maximum personnel utilization and the coronary care assistant" was conceived which, stated simply, is as follows: Enough qualified graduate trained nurses do not exist in most rural areas to staff such units. However, all licensed hospitals do and must have a certain number of graduate nurses to man the key positions, i.e. Director of Nurses, Nurse Supervisor, Chief Floor Nurse, Operating Room Supervisor, etc. As in almost all occupations.

* Surgeon, Heart Disease and Stroke Control Program, U.S.P.H.S.
† General Practitioner, Claxton, Georgia, and Assistant Clinical Professor of Medicine, Department of Medicine, Medical College of Georgia, Augusta, Georgia.

certain duties cannot be delegated while other duties are considered routine and can easily be performed by someone with less formal training. The concept was to train these key people in the dual role of maintaining their present positions but, at the same time, serve a "split shift" as supervisor in the coronary care unit.

For example, the operating room nurse or nurse anesthetist does not operate or give anesthesia the full eight hours every work day. The split shift or dual capability would allow her "expertise" to be utilized to the maximum. Hence, the concept "maximum personnel utilization." For this concept to function successfully two things are required:

1. The availability of less sophisticated personnel to carry out the routine task of the prime nurse when she is functioning in her "other role" and,
2. Delineation of clear-cut areas of responsibility and time of duty, i.e. the nurse anesthetist could not possibly have responsibility for the coronary care unit while performing her prime function as anesthetist.

The first of the above requirements, i.e. to provide less sophisticated personnel to make routine observations and carry out simple nursing tasks in the coronary care unit as a "coronary care assistant" will be described shortly. The second of the above prerequisites has been very successfully carried out in our institution by the Chief of Coronary Care Nurses who makes all the assignments and sees to their proper execution.

Ancillary Support

To provide the secondary personnel for ancillary support a group of young, enthusiastic, intelligent persons with less formal nursing education were trained as "coronary care assistants." The group consisted of one registered nurse, eight practical nurses, one ward secretary, one lab technician, one auto mechanic (recently discharged from the U. S. Army with excellent technical training), and two housewives and secretaries. The training of this group involved the same methods and covered the same subjects as described above; however, it involved considerably more time and slightly less detail. Classes were held four times each week; three afternoon sessions of 40 minutes and one evening session of 90 minutes. The average length of training was six months and the following subjects were presented: lectures on the physiology and anatomy of the circulatory system, the nursing care of the acutely ill cardiac patient, congestive heart failure, shock, emotional aspects of coronary care, commonly used medications, cardiopulmonary resuscitation,

defibrillation, and recognition and therapy of arrhythmias. Whenever possible ancillary teaching methods were utilized. These included models, charts, diagrams, etc.

Several aspects of training deserve emphasis. Of particular value were animal laboratories in which an anesthetized, intubated dog was monitored, defibrillated and resuscitated by each trainee. Arrhythmias were produced using digitalis, potassium and other drugs to demonstrate the optimal utilization of heart rate meters, alarms, oscilloscopes and especially the memory loop device. The trainees were urged to spend as many additional hours as possible observing in the coronary care unit with a trained coronary care nurse.

Physical Characteristics

The Coronary Care Unit is a self-contained unit consisting of three rooms—two patient rooms separated by a central nursing and monitoring station. Each patient's room contains one bed, oxygen and suction equipment as well as a bedside monitor with pacemaker, rate alarm and oscilloscope. The central unit contains rate alarms and oscilloscopes for both beds, as well as a direct writer and memory loop. One defibrillator and a full stock of intravenous catheters and fluids, all necessary medications and cut-down trays are kept in the central nursing station.

Patients

This report briefly summarizes the care of the first 27 admissions (25 patients) to the C.C.U. in the first nine months of operation by their private physicians because of a rhythm disturbance or the presumptive diagnosis of acute myocardial infarction. All patients were examined initially by one of the authors. The patients were monitored continuously, hourly rhythm strips were obtained, and rhythm abnormalities were recorded utilizing the memory loop. Intravenous catheters were inserted immediately after admission in all patients. Oxygen therapy was not routinely employed. Anticoagulation was left to the discretion of the private physician. Arrhythmias were generally treated according to current concepts of coronary care.¹¹ (See table for details.) Pacemakers were not employed because fluoroscopic equipment with image intensification was not available.

Acute myocardial infarction diagnosed by classical history, electrocardiographic changes (with evolution) and enzyme elevation occurred in 17 of 27 admissions. Patients #5, 13, 15, 16 and 19 had moderate to severe angina without evidence of serious arrhythmia or infarction. Patient #1 had digitalis toxicity, and patient #8 had complete heart block

CORONARY CARE / Bartel, Hames

with shock and coma. Patient #21 experienced unexpected ventricular fibrillation while on the general ward.

Results

Details presented in Table 1 indicate the individual diagnosis, major arrhythmias, treatment and outcome in each case. The average duration of monitoring was 3.3 days. There were no significant side effects of therapy.

Four patients died. Patient #11 suffered an extensive lateral wall infarction, multiple arrhythmias, hypotension and urinary tract obstruction. He was transferred to a larger hospital for relief of the obstruction, and died there seven days after infarction. Patient #18 developed an extensive anterolateral wall infarction, persistent chest pain and intractable congestive heart failure, and expired three days after admission to the unit. Sudden, unexpected ventricular fibrillation occurred in patient #21 on the general ward. She was defibrillated twice by the C.C.U. staff but remained in coma until expira-

Patient No.	Age and Sex	Major DX	Major Arrhythmias	Therapy	Other Complications in C.C.U.	Final Results
1	90 F	C.H.F. and dig. tox.	Atrial tach. with A-V dissociation	D/C Dig.	C.H.F.	Alive and well
2	47 M	Anterolateral infarction	V. tach. X2 Supravent. tach. and mult. PAC's	Lidocaine Lidocaine	None	Alive and well
3	48 M	Diaphragmatic infarction	Sinus bradycardia V. tach. X1 Transient 2nd and 3rd degree block	Atropine Lidocaine Atropine and Isuprel	Transient shock and C.H.F.	Alive and well
4	63 M	Diaphragmatic infarction	Prolonged P-R Supravent. tach.	None Carotid massage; electric cardioversion	Shock; active duodenal ulcer	Emboli—leg and cerebrum; angina
5	64 M	Coronary insufficiency	None	None	None	Alive and well
6	56 M	Diaphragmatic infarction	Sinus bradycardia Prol. P-R V. tach. X1 Mult. PVC's Wenckebach and sinus arrest	Atropine None Lidocaine Lidocaine None	None	Alive and well
7	66 M	Diaphragmatic infarction	V. tach. X1 Mult. PVC's Short run supravent. tach.	Lidocaine Lidocaine None	None	Alive and well
8	70 F	C.H.B. shock	Complete heart block	Isuprel drip	Shock; coma	Permanent pacemaker; alive and well
9	68 M	Anterolateral infarction	Nodal tach. Mult. PVC's Atrial flutter Supravent. tach. (short)	Carotid massage Lidocaine Electric countershock None	Hypotension Hypotension	Alive and well
10	58 M	Diaphragmatic infarction	Sinus bradycardia V. tach. X2 Short supravent. tach. Intermittent Wenckebach	Atropine Lidocaine None None	Shock (on levophed 2 days)	Alive and well
11	67 M	Acute lateral wall infarction	Atr. flutter with block Wenckebach Complete heart block A-V dissociation Multiple PVC's plus V. tach.	Isuprel and Atropine Lidocaine	Hypotension	Transferred because of urinary tract obstruction; died 5 days after transfer
12	33 M	Acute anterolateral infarction	None	None	None	Alive and well
13	80 F	Coronary insufficiency	Occ. PAC and PVC's	None	None	Alive and well
14	57 M	Muscle strain chest wall	None	None	None	Alive and well

Patient No.	Age and Sex	Major DX	Major Arrhythmias	Therapy	Other Complications in C.C.U.	Final Results
15	49 M	Atypical angina radiculitis	None	None	None	Alive and well; acute M.I. 2 mos. later; see patient #22
16	79 F	Coronary insufficiency	None	None	None	Alive and well
17	54 M	Acute cholecystitis	None	None	None	Alive and well
18	60 M	Acute anterolateral infarction	Rapid atrial fib.	Digitalis	Intractable C.H.F.	Expired; intractable C.H.F.
19	48 M	Syncope and angina	None	None	None	Alive and well
20	67 M	Diaphragmatic and lateral wall infarction	Mult. PVC's V. tach. (multiple runs) Suprevent. tach. (multiple runs) Atrial fib. (recurrent)	Lidocaine Lidocaine Dilantin Quinidine None Digitalis	C.H.F.	Discharged in moderate C.H.F. Second infarction one month later; see patient #24
21	67 F	Unexpected ventricular fibrillation	Vent. fib. (X2) Vent. tach. (multiple runs)	Cardioversion Lidocaine	Coma	Died in coma 2 days after admission
22	49 M	Diaphragmatic infarction	None	None	None	Alive and well
23	68 M	Diaphragmatic infarction	None	Digitalis Diuretics	Severe C.H.F. and pulmonary embolism	Died 2 days after admission
24	67 M	Anterolateral wall infarction	Supravent. tach. Vent. flutter and vent. fib. Atrial fib.	Cardioversion Cardioversion (nine times) Digitalis and Quinidine	Moderate C.H.F.	Alive; moderate C.H.F.
25	55 M	Probable infarction	None	None	None	Alive and well
26	49 M	Lateral wall infarction	None	None	None	Alive and well
27	49 M	Lateral wall infarction	None	None	None	Alive and well

tion two days later. Patient #23 expired two days after acute myocardial infarction with severe congestive heart failure and pulmonary embolism.

Significant complications occurred in patient #4 who developed a supraventricular tachycardia which was electrically cardioverted because shock developed rapidly. Anticoagulants were not administered because of active peptic ulcer disease. The patient was discharged from the C.C.U. on day five and on day 10 developed a femoral artery embolus. He was transferred to a larger hospital for embolectomy where he experienced a cerebrovascular accident from which he is recovering well.

Patient #8 was admitted in profound shock, coma and complete heart block. She responded to an Isuprel drip with an increase in heart rate and a permanent transvenous pacemaker was inserted at another hospital after unsuccessful attempts were made to pass a "flow directed" pacing catheter under electrocardiographic control.

Ventricular tachycardia, occasionally in repeated bursts, occurred in 8 patients and was controlled in most instances with Lidocaine. Multiple episodes of ventricular fibrillation and ventricular flutter responded to electrical cardioversion in patient #24.

Transient second or third degree A-V block with a ventricular rate below 50 in four patients responded to drug therapy.

Shock developed in four patients and improved in patients #3, 4 and 8 when normal sinus rhythm was restored. In patient #10 norepinephrine drip was necessary for 48 hours following infarction.

Although this paper was not intended primarily for analysis of the occurrence of arrhythmias and results of therapy, it should be noted that "life threatening" arrhythmias occurred in 12 patients, two of which expired. In most of these, the occurrence of serious arrhythmias was coincident with a sudden downhill course which was reversed dramatically with the restoration of normal rhythm.

Discussion

With the advent of Coronary Care Units in 1962, it has been repeatedly demonstrated that the large urban hospital can adequately equip and maintain a Coronary Care Unit, train and staff such a unit, and significantly lower the morbidity and mortality of arrhythmias in acute myocardial infarction.¹⁻⁷ The medical care of acute myocardial infarction in remote areas of the country will be greatly facilitated by a Coronary Care Unit which is immediately accessible, obviating transportation of an acutely ill patient during the most critical period of his illness. Aside from rapid admission to a coronary care facility, other benefits of local hospitalization include active participation by the family practitioner, close proximity to home, relatives and friends, and diminishing the burden of the urban centers relative to medical care of the acutely ill patient.

The Evans Memorial Hospital, a 42-bed facility serves approximately 10,000 persons within a 20 mile radius. The demand for coronary care becomes quite obvious upon perusal of the hospital admitting diagnoses. The 25 patients presented in this study include those with characteristic symptoms of infarction or arrhythmia. Many cases of less classical, atypical or mild chest pain were not admitted to the unit initially.

The greatest problem encountered in unit operation has been the acquisition and training of coronary care personnel. As described in the "methods" section, the coronary care nurses initially trained are complemented by a group of "coronary care assistants" who similarly receive extensive training in coronary care nursing and who rely on the coronary care nurse for direct supervision, frequent patient and electrocardiogram checks and immediate availability when necessary. The use of the memory loop has proven invaluable since any suspected arrhythmia can be recorded and discussed with the coronary care nurse and physician (a very important phase of teaching). In addition, when preset high or low rates have been reached and the alarm sounds, a rhythm strip immediately preceding the alarm is permanently recorded. This obviates difficulties of misrepresentation of the oscilloscopic tracing and the recall and description of what had transpired several seconds or minutes previously. The use of rapidly effective medications of low toxicity such as xylocaine and atropine has also added a new dimension to coronary care especially in small units with less sophisticated personnel and equipment.

Late developments in communications have made

available a system for transmission of electrocardiograms via the telephone lines for instant interpretation by experts, thus "bringing the consultant" into the local community. This should greatly benefit the patient, physician and coronary care staff. With the aid of the Regional Medical Programs (U.S.P.H.S.), the system will soon be employed in this hospital in connection with the Division of Cardiology, Medical College of Georgia.

The patient data demonstrates that severely ill patients with acute myocardial infarction experiencing multiple and life threatening arrhythmias can be effectively treated in a small coronary care unit, utilizing local personnel. Even without the benefit of numerous consultants, house staff, elaborate laboratories and catheterization equipment, a coronary care unit in a small community hospital can contribute to the prevention of possible debility and death from cardiac arrhythmias.

Summary

(1) The plan of operation for a two-bed coronary care unit in a small rural community hospital is presented. It could serve as a model for other small rural hospitals.

(2) The occurrence and treatment of serious arrhythmias in the first 27 admissions to the unit are described.

(3) The benefits of coronary care in remote areas are discussed.

(4) The concept of maximum personnel utilization centered around the "Coronary Care Assistant" is developed.

Hames Clinic
2 North Newton Street

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INDEXING WORDS

Coronary Care Units
 Coronary Care Assistants
 Myocardial Infarction

COUNTY MEDICAL SOCIETIES OF GEORGIA

Medical Society	President	Secretary	Meeting Date
Altamaha	E. J. Virusky, Baxley	Chester B. Kanavage, Baxley	2nd Wed.
Baldwin	R. J. Boyd, Milledgeville	Wm. Howard, Milledgeville	
Barrow	C. B. Skelton, Winder	J. K. Adams, Jefferson	1st Fri.
Bartow	Austin Flint, Cartersville	W. C. Holmes, Cartersville	Quarterly
Ben Hill-Irwin	C. H. Durden, Fitzgerald	Morgan Smith, Fitzgerald	
Bibb	C. R. Ireland, Macon	Lil L. James, Macon	1st Tues.
Blue Ridge			
Ogeechee River Med. Soc.	C. E. Bohler, Brooklet	R. L. Pence, Metter	2nd Tues.
Burke	J. M. Byne, Jr., Waynesboro	C. G. Green, Waynesboro	1st Tues.
Carroll-Douglas-Haralson	T. E. Reeves, Jr., Carrollton	J. E. Parrish, Carrollton	1st Mon.
Georgia Medical Society	L. Lee, Jr., Savannah	H. H. McGee, Jr., Savannah	2nd Tues. except Summer
Chattahoochee	C. B. Teal, Lawrenceville	R. H. Bramblett, Cumming	
Cherokee-Pickens	Wm. H. Nichols, Canton	D. T. Darnell, Tate	3rd Fri.
Crawford W. Long	G. S. Hinton, Athens	W. B. Mulherin, Athens	1st Tues., April, June, Sept., & Dec.
Clayton-Fayette	Wells Riley, Jonesboro	F. A. Sams, Jr., Fayetteville	3rd Tues.
Cobb	W. T. Williams, Smyrna	F. N. Bowles, Jr., Austell	
Coffee	R. L. Benson, Douglas	T. K. Stapleton, Douglas	3rd Tues.
Colquitt	R. E. Fokes, Moultrie	R. M. Joiner, Moultrie	2nd Mon.
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DeKalb	Timothy Harden, Decatur	S. Angier Wills, Decatur	3rd Mon.
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Camden-Charlton	Eduardo Oliveira, St. Marys	H. H. Robinson, Kingsland	1st Mon.
Emanuel	C. E. Powell, Swainsboro	H. Wilder Smith, Swainsboro	2nd Mon.
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Prompt evaluation of the urinary tract for possible injuries should be undertaken in any individual sustaining blunt abdominal trauma of any magnitude.

Injury to the Kidney and Urinary Bladder in Blunt Abdominal Trauma

DONALD J. MCKENZIE, M.D., F.A.C.S., *Thomasville*

SEVERE INJURY TO THE KIDNEYS and urinary bladder may occur with no external evidence of trauma. In automobile accidents, sudden impact against the door armrest has resulted in complete hemisection of the kidney without external evidence of trauma.¹ Statistically, extraperitoneal rupture of the urinary bladder has been far more common than intraperitoneal rupture when occurring together with fracture of the bony pelvis.² High speed impact of the individual with distended urinary bladder against a relatively tight seat belt is more likely to result in intraperitoneal rupture.

Prompt evaluation of the urinary tract for possible injuries should be undertaken in any individual sustaining blunt abdominal trauma of any magnitude.

Case Report: Injury to the Kidney

D. S., a 28-year-old white male motorcycle rider was admitted to the Emergency Room on 4/11/66, following a collision with an automobile. The patient was unconscious. The blood pressure was 72/0, the pulse was 140 per minute and thready. A rapid infusion of Ringer's Lactate maintained the blood pressure at 86/50. The pulse continued to be quite rapid and thready. A chest x-ray revealed fractures of the 7th through 11th ribs laterally on the left side as well as the transverse process of L-5. Fractures were noted involving the left wing of the sacrum and both superior and inferior pubic rami. A cystogram was done revealing no evidence of extravasation. Intravenous pyelogram employing 60 cc. of 50 per cent Hypaque revealed an intact and apparently normal right renal collecting system. No dye was seen in the left side and the left renal shadow was quite large.

At the time of exploratory laparotomy, no blood

was seen in the peritoneal cavity. The spleen was not ruptured. A massive retroperitoneal hematoma was noted on the left side. The left posterior peritoneum was incised and rubber-shod pedicle clamp applied. Inspection following this revealed a rupture involving the capsule and parenchyma of the left kidney. It was not felt that hemostatic sutures could be adequately positioned in order to control bleeding and a nephrectomy was done immediately.

Postoperatively, the patient's vital signs stabilized. A concomitant cerebral concussion delayed his hospitalization and he was discharged on the 11th postoperative day.

Reasons for Renal Trauma

Two basic mechanisms account for a high degree of renal trauma. Sudden deceleration, such as in a high speed automobile collision, may cause avulsion of the renal pedicle or "aberrant" vessels supplying the renal parenchyma. Secondly, blunt external trauma may wedge the kidney against the vertebral column. This is not infrequently associated with fractures of the lower ribs and transverse processes.

In surveying the extent of damage it is of equal importance to evaluate the contralateral kidney as it is to ascertain the degree of damage to the injured kidney. In the absence of severe hypotension we have used a "double dose" I.V.P. in visualizing the collecting systems.

Use of infusion pyelogram techniques approaching 1 cc. of dye per pound of body weight may still fail to give adequate visualization of the renal collecting system in patients with severe hypotension and consequently markedly decreased renal perfusion. Others have pointed out the potential side effects using high dosages of contrast media in severe fluid depletion.³

Cystoscopy with bilateral retrograde pyelograms

From the Department of Urology, John D. Archbold Memorial Hospital, Thomasville, Georgia.

is effective in outlining the renal collecting systems. Either retrograde femoral or translumbar aortograms could be used to study the renal vasculature.

Traditionally, the indications for exploration are enlarging flank mass with associated hypotension and falling hematocrit. Failure of dye excretion is not an indication for exploration and is not a useful parameter in estimating the extent of renal damage.⁴

The vast majority of renal injuries in the past have been treated non-operatively. In the presence of stable blood pressure, pulse, and hematocrit a conservative approach is indicated. In the event that exploration may become necessary a transabdominal approach is the most desirable since this affords rapid and better access to the renal pedicle.

Followup I.V.P. should be done after resolution of the renal injury. In the vast majority of cases return to normal appearing collecting system with excellent drainage occurs.

Bladder Injury

Case History: T. R., a 14-year-old white male, was admitted to the hospital via Emergency Room on 6/3/66. The patient had fallen while horseback riding and sustained a direct blow to the lower abdomen by the horse's hoof.

Physical examination was essentially negative except for rather generalized abdominal tenderness. Peristaltic sounds were normal and there was no point or rebound tenderness.

A #16 French rubber catheter was introduced into the bladder and 50 cc. of dark amber urine obtained. On microscopic examination 40-50 red blood cells were noted on the unspun specimen. 150 cc. of 10 per cent cystokon were instilled into the bladder under 15 cm. gravity flow. A single A-P film was made. This revealed an apparently normal bladder contour sharply delineated. No dye extravasation was noted. No fracture of the bony pelvis was evident. Significantly, no semi-lateral or lateral films were made. The cystokon was allowed to drain completely. The volume was not measured. No further films were obtained. Exploratory laparotomy was decided upon and urologic consultation secured at that time. 175 cc. of sterile saline with two ampules of indigo carmine were instilled into the urinary bladder and the catheter was clamped.

On opening the peritoneal cavity indigo carmine was noted. Examination of the posterior wall of the urinary bladder revealed a 4 cm. long laceration. A suprapubic cystostomy was constructed and the bladder defect was closed with #00 chromic catgut. No bleeding occurred postoperatively and the catheter was removed in three days. The urethral catheter was removed on the fifth postoperative

day and the patient discharged on the seventh postoperative day.

Perforation of the urinary bladder with consequent extravasation of urine requires immediate surgical intervention. High mortality rates parallel delay in surgical exploration.⁴ Extraperitoneal rupture of the bladder occurs most frequently with trauma to the bony pelvis. Fracture of the pelvis is frequently the causative factor, a bony spicule lacerating the bladder on the anteriolateral surface of the bladder neck. Intraperitoneal rupture is most commonly associated with a distended bladder sustaining blunt abdominal trauma. Diagnosis is made by cystogram. In performing cystogram it is important to utilize enough opaque media to adequately distend the bladder and to take oblique films as well as A-P. In an early cystogram following an intraperitoneal rupture dye may be sequestered behind the urinary bladder and completely masked by a bladder distended with opaque media anterior to it.

Summary

Two cases of injury to the urinary tract following blunt abdominal trauma are presented. The case report illustrating injury to the kidney required nephrectomy. Traditionally, injury to the kidney has been treated conservatively with excellent results.^{5, 6} Operative intervention is indicated only in cases of massive hemorrhage not responding to conservative treatment. With increasing incidence of high impact motor vehicle injuries the likelihood of increased severity of renal injury is foreseeable. Non-visualization on I.V.P. films is not an indication for exploration nor is it an indicator of ultimate renal function.

Evidence of rupture of the urinary bladder is an indication for immediate surgical exploration. Diagnosis is made by retrograde cystography employing a urethral catheter. Adequate distention of the bladder with dye together with lateral and oblique films are essential. Closure of the bladder defect and adequate drainage are the primary principles of treatment.

818 Gordon Avenue

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The problem is current and pertinent
to the clinical practice of medicine in
Georgia.

Malaria in Georgia*

JULIAN JACOBS, M.D.,[†] *Atlanta*

THE EXPECTED ANNUAL RETURN of 450,000 to 650,000 servicemen from Vietnam in the relatively near future poses a problem for the practicing physician in Georgia as well as elsewhere in the United States: the diagnosis and treatment of malaria. A clinical attack rate of approximately 1 per cent in returned veterans raises the possibility of 4,500 to 6,500 clinical episodes of malaria. Figure I presents the incidence to date in the U.S.

FIGURE I
CLINICAL EPISODES OF ALL TYPES OF
MALARIA IN THE UNITED STATES
January 1, 1966-December 31, 1969*

Where Diagnosed	Number
Military hospital	7,959
VA hospital	1,662
Civilian hospital	695
PHS hospital	126
Other facilities	45
No hospitalization	78
Unknown	44
Total	10,609

* As reported to CDC as of January 23, 1970.

Thus far in Georgia there has been from January 1, 1966 to December 31, 1969 a total of 850 clinical episodes. The majority has been at military bases but the Atlanta VA Hospital has had nearly 50 patients, mostly referred from private physicians. The yearly incidence in the U.S. is shown in Figure II. The importance to the civilian physician is that the infection acquired while in military service may become manifest after discharge from the military or while the serviceman is on leave in his community.

The relapsing group of malaria in the non-immune individual is capable of producing significant prostration but is not lethal. However, Falciparum

malaria, or the non-relapsing type, is a potentially fatal disease if not diagnosed and treated early. Fortunately, most clinical episodes of malaria in the United States are of the relapsing group, usually Vivax, but Falciparum does occur and requires different therapy. All cases of Falciparum acquired in SE Asia and South America should be considered resistant to chloroquine and other synthetic antimalarials. No figures are available for Georgia as to the distribution of the types, but the distribution would probably resemble that for the entire United States as noted in Figure III. It is of importance to note that 11/20 deaths between 1966 and 1969 were in civilian hospitals. The three additional deaths in individuals never hospitalized occurred in civilians who did not seek medical care. Early diagnosis and therapy of Falciparum is

FIGURE II
CLINICAL EPISODES OF MALARIA IN GEORGIA
(LABORATORY CONFIRMED)
January 1, 1966-December 31, 1969*

1966	55
1967	229
1968	226
1969*	270

* As reported to CDC as of January 23, 1970.

FIGURE III
CLINICAL EPISODES OF FALCIPARUM MALARIA
IN THE UNITED STATES 1966-1969*

Where Diagnosed	Number	Deaths
Military hospital	989	4
VA hospital	229	0
Civilian hospital	159	11
PHS hospital	47	2
Other facilities	5	0
No hospitalization	15	3
Unknown	8	0
Total	1,452	20

* As reported to CDC as of January 23, 1970.

* From the Medical Service of the Atlanta Veterans Administration Hospital, and Department of Medicine, Emory University School of Medicine.
[†] Chief, Hematology Section, Atlanta VA Hospital, and Assistant Professor of Medicine (Hematology), Emory University School of Medicine.

FIGURE IV
GUIDES IN THE DIAGNOSIS OF MALARIA
BY THE PERIPHERAL BLOOD SMEAR

Relapsing Group	Falciparum
Large ring forms	Crescent shaped gametocyte (pathognomonic if present)
Schuffner's stippling frequent	Small ring forms
Intermediate forms (Trophozoites and Schizonts)	No Schuffner's stippling
Parasitized cells usually larger than non-parasitized cells	Only ring forms
	Parasitized cells usually smaller than non-parasitized cells
	Parasite at margin of RBC

FIGURE V
TREATMENT OF MALARIA

Falciparum	Relapsing Types
Quinine—600 mg. p.o. q.8h, x 10 days (If I.V. in comatose patients, 600 mg. in 600 cc. of saline over 45-60 minutes with blood pressure and ECG monitoring q.8h until oral therapy possible.)	Chloroquine Phosphate 1000 mg. immediately (500 mg. Chloroquine base) 500 mg. after 6 hours (300 mg. base) 500 mg. second day 500 mg. third day
Pyrimethamine (Dara-prim®) 25 mg. t.i.d. x 3 days	Primaquine—one 26.3 mg. tablet (15 mg. base) daily x 14 days
Sulfadiazine—500 mg. q.i.d. x 7 days	Relapse rate—10-20%; may recur after 1-2 years
Followup for 90 days.	

critical. Eight deaths were reported thus far from Falciparum in 1969 as compared to four deaths in 1967 and six in 1968. No deaths have been reported from Falciparum in Georgia, although one Atlanta VA Hospital case was critically ill with renal failure and cerebral malaria. With large military bases in Georgia, we can expect an increasing number of cases as troops return.

Fever in a young veteran or serviceman on leave, or a returned tourist, who has been in a malarious area is enough to institute a search for malarial parasites in the blood. Delay in diagnosis which allows extremely high parasite counts to develop is responsible for the fatalities in Falciparum malaria. Figures IV and V are guides for the differentiation of Falciparum malaria from the Relapsing Group, and the proper therapy. Two recent publications^{1, 2} go into detail regarding the clinical features, therapy, complications, and current information in the broader aspects of malaria.

Clairmont Road, N.E.

Data in Figures I-III was supplied by Malaria Surveillance, Parasitic Diseases Branch, National Communicable Disease Center, Atlanta, Georgia.

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Sixth Annual

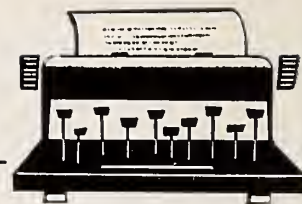
RURAL HEALTH CONFERENCE

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Plan to Attend!



Thermal Burns

SAVE FOR THE EFFORT OF A MEDICAL STUDENT, 1970 would have passed and gone without anyone realizing that it was the 100th anniversary of the first successful skin graft. More startling is the fact that the first successful homograft was applied in the same wound. George D. Pollack, an English surgeon, transferred one and one half inch square pieces of skin on successive occasions to a recipient site in a young patient's leg 100 years ago with a successful rehabilitative effort. Simultaneously, during these staged grafting procedures and utilizing skin from a black donor, he noted the progress and rate of growth with ultimate rejection of homografts.

Burn Occurrence and Other Data

Despite an increased interest in the treatment of thermal burns, the development of burn centers, engineering abilities improving safety factors in heating equipment and appliances, etc., there is a steadily increasing incidence of burns admitted to the hospital. Sometime ago it was projected that, based on population expansion, a 20 per cent increase in patient census would result. Detailed studies in sample areas confirm that this has occurred already. Two million burn injuries occur each year in the United States. At least one-fourth of these injuries require some type of bed care (usually hospitalization). Yearly there are 8,000 deaths (State of Georgia—1968—295). Thirteen per cent of the deaths occur in the one-to-four age group, and another high mortality group are those over 55.

Economists, evaluating the burn problem, show a loss of a quarter of a billion dollars each year as a result of fire. The majority of burns occur in the home environment, usually between 3 and 9 o'clock p.m. More frequently than not, severe injury is the direct result of inadequate flame retardant clothing. Authorities note that though a flammable fabrics act has existed for two and one half years, the basic standards are inadequate and enforcement is poor.

The thermal burn injury of any severity (that is, 3rd degree in depth and 30 per cent or more of the surface area involved) is a challenge that encompasses most of the facets of medical practice. Basically the burn therapist needs an intimate knowledge of fluid and electrolyte balance, metabolic changes, microbiology, and must, at the same time, draw on basic surgical principles, as well as the assistance that can be obtained from plastic and orthopedic surgical techniques. Becoming involved in burn care, the physician relies on a whole host of ancillary personnel to achieve a satisfactory result. The majority of physicians treating burns are surgeons, most of whom trained themselves in the use of techniques outside their own specialty. However, today, with an increasing number of burn units already functioning, present and future trainees are able to develop techniques within such centers.

Topical Chemotherapeutic Agents

Within the past few years both ½ per cent silver nitrate and Sulfamylon® have proven to be of marked benefit and are readily available. A newer topical agent, silver sulfadiazine ointment, has been demonstrated to be equally effective and practical, although at the moment has not been released for use by the FDA

until further clinical case studies have been accumulated, but there remains little question as to its ultimate approval. Another well-known type of topical therapy utilizing Gentamycin impregnated gauze still remains under consideration by the FDA. It must be pointed out that topical agents are not a panacea, and are only one aspect of therapy. Other new and old methods of burn treatment have to be carried on simultaneously for effective and ultimate treatment.

Sepsis

The majority of deaths in patients with thermal burns is still the result of septicemia, and pneumonia a moderately distant second. Most septicemia today is due to *Pseudomonas*, although in the past one and one half to two years it is apparent that *Aerobacter* is becoming an increasingly clinically significant organism. In burn wound sepsis, very frequently two organisms—*Pseudomonas* and *Staph*, or *Pseudomonas* and *Aerobacter*—may be prominent invaders with, or without, the existence of concurrent septicemia. Parenteral antibacterial therapy is very important regardless of the type of topical therapy used.

Recent studies show that at least half of the cases of septicemia occur within the first week post-burn and that 25 per cent occur as early as the first 48 hours. Gram-negative invasion is much more prevalent than gram-positive, but in choosing antibiotics for burn therapy, one must not overlook the latter. Of interest is the fact that in patients with septicemia, Polymyxin B has probably proven to be the most effective antibiotic. It is expected that one of the principal reasons is that it has been less widely used than other antibiotics that are more commonly associated with therapeutic efforts in the gram-negative septicemia patient.

We are about to have available for general use an effective vaccine for the treatment of the burn patient with *Pseudomonas*, and treatment can also be supplemented with the use of an immune serum. To date increased efforts with these types of therapy are showing evidences of fruition.

Homografts

The use of homografts and their effectiveness in temporary coverage of the burn wound is well documented. In some areas cadaver skin is available in large amounts but, in general, existing laws, regulations, etc. prohibit the routine accumulation of such skin for surgical dressings. Likeness of young pigskin to human skin in structure has stimulated the increased use of this latter type of coverage, since it bypasses such existing restrictions as mentioned above.

Fungal Infections

As in any patient with chronic disease of a debilitating nature in whom extensive antibiotic therapy is utilized, invasive fungus is an increasingly prevalent problem. The most frequent of the offending organisms of this type are *Candida*, *Aspergillus* and *Mucor* (phycomycosis). At present the most rapid way of determining fungal infections is a familiarity, first, with the fact that they occur, recognizing the type of change that fungus will produce, proving it by histology techniques rather than culture growth. Treatment consists of a combination of surgical and chemotherapeutic methods.

Curling's Ulcer

The occurrence of Curling's ulcers have recently been documented as being more frequent than actually expected, and also occurring much earlier (within 48 to 72 hours) than heretofore believed. Curling's ulcers are not nearly as rare as previously believed. Upper GI series early in the course of the burn patient document the existence of more ulcers than was suspected.

The Burned Hand

Because of the frequency of burns in the hand and the poor long-term results, a more aggressive surgical attack is recommended. As in burns elsewhere in the

body, a combination of treatment is necessary, of course, but it has been recently stressed that particularly in the hand early debridement and skin grafting, combined with early active motion, results in less permanent hand damage than we have experienced previously with other methods. Physiotherapy should be begun immediately after burning, continued on a one-hour frequency basis right through the swelling, debridement, grafting, etc., and at no time should hands and arms be allowed to be dependent.

Pat C. Shea, Jr., M.D.
Saint Joseph's Infirmary
Atlanta, Georgia 30303

Committee Conclave

THE THIRD ANNUAL CONCLAVE OF COMMITTEES will be held on Saturday and Sunday, August 15-16, 1970, at the Marriott Motor Hotel, Atlanta. Since its inception in 1968, the concept of the Conclave of Committees has served to strengthen and improve the operational effectiveness of the Medical Association of Georgia. Through the meetings of 33 MAG operating committees in the same location at the same time, intra-committee relationships will be maintained making possible direct dialogue between committee members, charmen and the officers of the Association. MAG members are invited to attend any committee holding special interest for them so that the committee will have the benefit of their counsel.

SAT. AUG. 15	STONE MOUNTAIN	HICKORY HILL	TWELVE OAKS	THORNWOOD	WHITEHALL	WREN'S NEST
9:30 a.m.- 11:30 a.m.		LEGISLATION Chm.: J. Frank Walker, M.D.	NURSING LIAISON Chm.: Charles Eberhart, M.D.	PUBLIC RELAT. Chm.: J. Watts Lipscomb, M.D.	MEDICINE AND RELIGION Chm.: W. H. Pool, M.D.	BLOOD BANKS Chm.: Lee Howard, Jr., M.D.
11:30 a.m.—1:00 p.m.	LUNCH BREAK FOR ALL COMMITTEES					HOTEL RESTAURANTS
1:00 p.m.- 2:00 p.m.	PROFESSIONAL CONDUCT AND MEDICAL ETHICS Chm.: T. A. Sappington, M.D.	CONSTITUTION AND BYLAWS Chm.: George H. Alexander, M.D.	CRIPPLED CHILDREN Chm.: Harry R. Foster, M.D.	RURAL HEALTH Chm.: Irving D. Hellenga, M.D.	DISASTER MEDICAL CARE Chm.: Virgil B. Williams, M.D.	AWARDS Chm.: John S. Atwater, M.D.
2:00 p.m.- 3:00 p.m.						FOUNDATION Chm.: Charles R. Andrews, M.D.
3:00 p.m.- 5:00 p.m.		ECOLOGICAL HEALTH Chm.: John Kirk Train, Jr., M.D.	ANNUAL SESSION Chm.: Preston D. Ellington, M.D.	MENTAL HEALTH Chm.: A. S. Yochem, M.D.	CANCER Chm.: Hoke Wammock, M.D.	FINANCE Chm.: Braswell E. Collins, M.D.
5:00 p.m.- 7:00 p.m.	ALLIED HEALTH CAREERS Chm.: John T. Godwin, M.D.	OCCUPATIONAL HEALTH Chm.: Tom S. Howell, M.D.	HOSPITAL ACT. Chm.: James M. Skinner, M.D.	EMERGENCY MED. SERVICES Robert E. Wells, M.D.	HISTORICAL Chm.: Milford B. Hatcher, M.D.	
7:30 p.m.—8:30 p.m.	RECEPTION		PLANTATION ROOM		CASH BAR	
SUN., AUG. 16	STONE MOUNTAIN	HICKORY HILL	TWELVE OAKS	THORNWOOD	WHITEHALL	WREN'S NEST
9:00 a.m.- 11:00 a.m.	PHYSICIAN LAWYER LIAISON Chm.: J. Frank Walker, M.D.	MED. REVIEW AND NEGOTIATING Chm.: John R. McCain, M.D.	GOVERNMENTAL MED. SERVICES Chm.: Charles B. Watkins, M.D.	MEDICAL EDUCA. Chm.: Luther G. Fortson, M.D.	MATERNAL AND INFANT WELF. Chm.: Eugene L. Griffin, M.D.	PERINATAL MORTALITY SUBCOMMITTEE Chm.: Malcolm Freeman, M.D.
11:00 a.m.- 1:00 p.m.	PRIVATE PRACTICE Chm.: Donald R. Rooney, M.D.	INSURANCE AND ECONOMICS Chm.: W. W. Moore, M.D.	AREAWIDE HEALTH PLANNING Chm.: F. W. Dowda, M.D.	SCHOOL CHILD HEALTH Chm.: Fred L. Allman, M.D.		
1:00 p.m.—2:30 p.m.	LUNCH BREAK FOR ALL COMMITTEES					HOTEL RESTAURANTS
2:30 p.m.	CHAIRMEN'S CONFERENCE AND EXECUTIVE COMM. OF COUNCIL					



PEER REVIEW ! WHO NEEDS ? WE DO !

WEBSTER DEFINES "PEER" in its nominative form as "an equal," "of the same rank or quality." But "peer" in its active verbal form means also "to look curiously, intently, or searchingly."

Both usages, paradoxically, are apropos in the present-day practice of medicine as it is related to or affected by governmental programs such as Medicare and Medicaid.

With the advent of government in the fields of medical care, and the use of tax funds in payment for health care, the complexion of the practice of medicine, as it has been pursued during the past several decades, has changed remarkably. Whether we like it or not, we as physicians must conform, not so much to governmental agency requirements, but to the demands of public opinion, which ultimately dictates methods and procedures in medical practice as well as governmental agency requirements.

In years past (the number depending on how many since!—) you must remember your instructor in physics repeating the old truth that "nature abhors a vacuum." We must not allow a "vacuum" consisting of either over- or underutilization procedures to occur. Physicians, in general, are mostly rugged individualists who instinctively resist someone, or something, bent on changing their minds. This is a good old solid American trait, but we must keep our cool, for the old adage that "he who pays the piper, calls the tune" is as true as ever. By continuing diligence, a reasonably flexible openness, and by making ourselves available for service on commissions, boards, authorities, etc., we can still materially determine decisions and influence vitally the maintenance of programs involving health care.

Why do we need "peer review?" To answer this question requires solutions to a number of problems:

Medicare—Titles XVIII and XIX, Public Law 89-97—calls only for in-hospital utilization review, but experiences in the interim since the law became effective reveals a need for expansion of review procedures—not only expansion of review procedures for utilization of hospital facilities but review of in-office procedures. Who is best qualified to do this? Certainly *not* laymen, but professionally trained persons, either in medicine itself or in disciplines closely allied.

A method must be evolved by which we can assure the public in general, the governmental agencies in particular, and ourselves specifically, that the patient is receiving adequate medical care for a fair fee.

The Rotary Club has the Four Way Test as a creed. If all parties concerned followed these rules, all else would be simplified:

1. Is it the truth?
2. Is it fair to all concerned?
3. Will it build good will and better friendship?
4. Will it be beneficial to all concerned?

PRESIDENT'S LETTER / Continued

Some years ago, I had the privilege of serving as Chairman of the Building Committee of my church, and also the responsibility of approving payment of contractors, architects, engineers, and other suppliers of material, labor, and services. The only stipulation in my acceptance of this assignment was that all financial affairs be audited by a certified accountant. The request brought the comment from a fine committee member that "we can trust you." Trustworthiness was not in question; but complete explanation of all accounts, based on professional analysis, enabled all parties concerned to see and have record of every penny disbursed in their behalf.

Peer review accomplishes the same end, and I approve it.



F. G. Eldridge, M.D.
President, Medical Association of Georgia

SYMPOSIUM '70 A SUCCESS

On Thursday and Friday, April 16-17, 1970, the Committee on Medicine and Religion of the Cobb County Medical Society in cooperation with Kennesaw Junior College, the Cobb Judicial Circuit Bar Association and the Marietta-Smyrna Ministerial Association sponsored perhaps its most successful and stimulating annual symposia program in its five-year history—"Symposium '70—Frontiers of the Mind."

This program was held as usual at Kennesaw Junior College and was attended by some 2,000 persons throughout Georgia and the surrounding southeastern states. Under the leadership of Dr. Luther G. Fortson, Symposium Chairman for 1970, this program achieved special significant status in being designated as the Annual Clergy Conference by the Episcopal Diocese of Atlanta which includes all Episcopal clergymen in the northern half of the state.

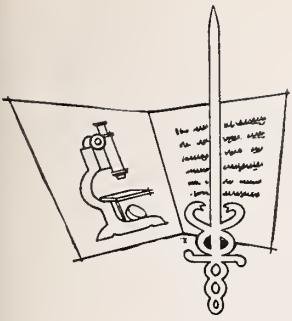
The outstanding speakers for Symposium '70 were Dr. Jose Delgado, world-renowned neurophysiologist, Yale University; Dr. James L. McGaugh, psychobiologist from the University of California; Mr. Albert Rosenfeld, managing editor of the magazine *Family Health* and for many years senior science editor of *Life* magazine; Dr. Kenneth L. Vaux, Professor of Ethics in the Institute of Religion in Houston, Texas, and Associate Professor in the Department of Psychiatry of the Baylor Medical School; Dr. Allen E. Smith, Professor of Law at the University of Texas

School of Law, and Col. R. H. Lang, Air Force Space Medicine, Department of Manned Space Program.

The entire symposium concerned itself with the problems related to the bio-medical, bio-technological and cybernetic revolution involving manipulation of the mind, artificial alteration of human behavior and anticipated problems in what Mr. Rosenfeld refers to as "the coming control of life." The dates of April 15-16, 1971, have been selected for Symposium '71. The anticipated topic will be "America Versus America—The Revolution in Values."



Panel discussion during Symposium '70, including (from l. to r.), Drs. Lange, Vaux, McGaugh, Delgado, and Smith.



ENTEROSTOMAL THERAPY—A NEW APPROACH TO OSTOMY CARE

HENRY M. FINCH, M.D., F.A.C.S., *Atlanta**

A COLOSTOMY . . . ILEOSTOMY . . . ureterostomy . . . or any other of the ostomy problems are not diseases; rather, they are a change of a bodily function to free the patient from the troubles of disease.

Colostomies are made for many different diseases and conditions, and therefore, there is no such thing as a standard colostomy. Sometimes they are temporary . . . sometimes permanent. Where cancer is concerned, they are frequently permanent. Although there are preferred sites for location, some are on the left side of the abdomen . . . others may be in the middle or on the right.

There is no one way to take care of a colostomy. Just as they differ, so does the management. Although they may vary considerably, they all have one thing in common: They must be taken care of!

Of a total projected 13,000 new cases of cancer developing in Georgia each year, it is estimated 1,030 of these will be new colon-rectal cancers, with at least one-third of these resulting in a colostomy. Other ostomy problems include those of ileostomy, ileal bladder or ureterostomy. Many of these procedures are performed for cancer.

The chance of cancer developing in ulcerative colitis, for which many ileostomies are performed, is 25 times as great as in the normal bowel. Hence surgery for ulcerative colitis is, in a sense, a form of cancer prevention.

In all cases, psychological adjustments to this type of surgery are frequently quite intense, and vary from patient to patient . . . from feelings of utter despair, frustration, degradation and domination of the ostomy by many who have them, to a general acceptance of the problems posed with some degree of ease and success by a few . . . depending upon the advice and care provided at the time surgery is performed.

With over 2,000 separate types of equipment available for such patients, no doctor or nurse could know all of the advantages or disadvantages of one over another without devoting full time to stomal care.

The importance of providing psychological help for ostomy patients by those who have the condition and successfully learned to manage it cannot be underestimated. Local Ostomy Groups, where they are organized, have provided a yeoman's service in this area for years. However, with the rapid development and expansion in this field of surgery in recent years, they cannot meet the demands. As volunteers they are not able to devote the time required nor are they equipped to furnish the professional guidance needed. To meet these demands, a new paramedical profession has developed . . . "Enterostomal Therapy."

* Chairman, Ostomy Counselling Service, American Cancer Society, Georgia Division.

In 1958, Dr. Rupert Turnbull of Cleveland Clinic, recognizing the problems ostomy patients have, asked one of his patients, Mrs. Norma Gill of Akron, Ohio, to come to Cleveland Clinic to train as a "Stoma Therapist." Her primary duties included in-hospital care of patients with ostomies, instruction and training of the patient in the care and management of the stoma, training in the home care of the patient, and ultimately fitting the various types of equipment where needed.

Miss Gill became the first "Enterostomal Therapist," although this name was not born until suggested by Dr. Turnbull at the organizational meeting in 1968 of others who had by then been trained and certified in this profession.

Rules and guidelines were established at this meeting in Phoenix, Arizona. The definition of an "Enterostomal Therapist" is, "An individual, male or female, equipped to understand the emotional and physical needs of ostomy patients. Such a person must receive training in an approved medical center, shall be remunerated for his services, and shall be supervised at all times by a physician."

Enterostomal Therapist

An "Enterostomal Therapist" is trained to provide pre-operative consultation to the patient, post-operative care of the stoma and equipment, emotional support, instruction in hospital and follow-up care, and referral to community resources in health and social welfare.

To the medical professions the therapist serves as liaison between members of the care-taking team, provides instruction in ostomy therapy and equipment, and gives demonstrations in stomal care practices. At all times she abides by the usual ethical practices of the medical profession.

Through the Volunteer Patient Service Program of the American Cancer Society, an Ostomy Counselling service is now being offered, with the assistance of Mrs. Jane Walker, the only "Enterostomal Therapist" in Georgia, and herself an ostomate of some 17 years, as consultant. A committee of physicians from the leading medical centers in Georgia will serve as a medical advisory committee to determine the functions and policies of this program.

The objective will be to develop a series of lectures or symposia to be scheduled in each hospital requesting it for in-service training of medical staff, including physicians and nurses, to include demonstrations of appliances, irrigation techniques, general ostomy care and related experiences of ostomy patients . . . to train "stoma therapists" in other areas of the state to help meet the needs of local patients, with the availability of the "Enterostomal Therapist" for consultation at all times, to assess needs of stomal patients, plan care on basis of these needs in consultation with the attending physician, and to teach stomal self-care to patients in hospitals, nursing homes, and in their own homes.

For information regarding this service, call your local unit of the American Cancer Society, or write the American Cancer Society, Georgia Division, Inc., 2025 Peachtree Rd., NE, Atlanta 30309. For information on the Georgia Ostomy Association, write Mrs. G. F. Brewer, President of the Georgia Ostomy Association, 3070 Beechwood Drive, SE, Marietta, Georgia 30060.

490 Peachtree St., N.E.

A man of very moderate ability may be a good physician, if he devotes himself faithfully to the work.

—Oliver Wendell Holmes



THE INCREASING ROLE OF SURGERY FOR CORONARY ARTERY DISEASE

ROBERT G. ELLISON, M.D., *Augusta*

IN SPITE OF ADVANCEMENTS made in the management of patients with coronary artery disease, the morbidity and mortality from this disease and its complications remain high. For this reason, surgical efforts have been increasingly aggressive toward development of methods for increasing the blood supply to the ischemic myocardium and improving the function of the left ventricle.

Credit is due Vineberg of Montreal for his pioneering efforts in improvement of myocardial blood flow by implantation of the internal mammary artery into the myocardium. His theories were supported with techniques of coronary arteriography developed by Sones of Cleveland. Initially, coronary arteriography suggested that the majority of patients with this disease had such diffuse obstruction that only a few would be candidates for direct surgery. Accordingly, implantation of the internal mammary artery, often bilaterally, was utilized to bring additional blood into the ischemic myocardium. An exact understanding of the anatomical pattern of disease was necessary to implant the internal mammary artery and its branches into ischemic areas in order for sufficient communications to develop. This procedure has been helpful in a significant number of patients. The disadvantage of this operation, however, is the time interval (often several months) necessary for the development of communications sufficient to bring relief of angina. For this reason, increasing efforts have been directed toward direct surgery, such as end-arterectomy, patch grafts and more recently the use of saphenous vein bypass grafts from the root of the ascending aorta to a coronary artery branch distal to the point of obstruction. Such grafts can be placed into any of the coronary arteries distal to the obstructed areas and frequently, regardless of the extent of disease, a branch sufficiently large can be found to effect a satisfactory anastomosis. Over 1,000 patients have been reported to have had surgery of this type with an operative mortality less than 10 per cent.

Results of surgical resection of post-infarction myocardial aneurysms have been good. Most of these patients are symptomatic from cardiac failure, low cardiac output or embolization.

Akinetic or non-functioning areas of left ventricular myocardium may impair cardiac output sufficiently to produce symptoms of fatigue and decreased exercise tolerance. In many instances these areas of poorly functioning myocardium can be resected, often combined with a procedure to increase coronary blood flow, at a respectable mortality rate and with worthwhile relief of angina and improvement in myocardial function.

Occasionally, ventricular septal defect follows extensive infarction of the lower portion of the ventricular septum. This acute defect is not well tolerated since the left-to-right shunt imposes an added burden upon the already poorly functioning myocardium. All such patients are seriously ill, but many can be salvaged with surgical resection of the infarction and closure of the defect.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Recent experimental studies have indicated improvement in myocardial function following resection of acute myocardial infarction. This principle has been applied clinically by operating upon patients early after myocardial infarction when cardiac output was so poor that survival seemed unlikely. An increasing number of successful cases is being reported.

Recent developments in techniques of coronary arteriography and of evaluating the integrity of the left ventricle along with increasing experience with extracorporeal circulation have led to an aggressive surgical attack for relief of angina and improvement of myocardial function. Results are sufficiently good and mortality rates sufficiently low so that all patients with coronary artery disease or resulting complications, in whom symptoms can not be adequately controlled medically, should have investigation of the coronary arteries and myocardium in consideration for surgery.

Medical College of Georgia

**SURVEY OF STATE ASSOCIATION DUES OF
ACTIVE MEMBERS—DECEMBER, 1969**

*(Following is a compilation of State Association dues of active members which might be of interest to
MAG members.)*

ALABAMA	\$ 75	MONTANA	\$100
ALASKA	\$200	NEBRASKA	\$ 70
ARIZONA	\$105	NEVADA	\$150
ARKANSAS	\$ 75	NEW HAMPSHIRE	\$ 95
CALIFORNIA	\$ 90	NEW JERSEY	\$ 55
COLORADO	\$ 70	NEW MEXICO	\$105
CONNECTICUT	\$ 50	NEW YORK	\$ 70
DELAWARE	\$ 85	NORTH CAROLINA	\$155
DISTRICT OF COLUMBIA	\$ 85	NORTH DAKOTA	\$125
FLORIDA	\$ 75	OHIO	\$ 50
GEORGIA	\$ 40	OKLAHOMA	\$100
HAWAII	\$140	OREGON	\$115
IDAHO	\$147	PENNSYLVANIA	\$ 75
ILLINOIS	\$105	PUERTO RICO	\$ 73
INDIANA	\$ 80	RHODE ISLAND	\$ 80
IOWA	\$150	SOUTH CAROLINA	\$ 75
KANSAS	\$ 75	SOUTH DAKOTA	\$125
KENTUCKY	\$ 80	TENNESSEE	\$ 80
LOUISIANA	\$ 85	TEXAS	\$ 55
MAINE	\$ 65	UTAH	\$115
MARYLAND	\$ 75	VERMONT	\$ 65
MASSACHUSETTS	\$ 60	VIRGINIA	\$ 60
MICHIGAN	\$125	WASHINGTON	\$ 97
MINNESOTA	\$100	WEST VIRGINIA	\$ 80
MISSISSIPPI	\$ 60	WISCONSIN	\$145
MISSOURI	\$ 60	WYOMING	\$ 75

(Average—\$92. High-Low Average—\$120. States Over \$100—18. Georgia's dues, \$40, are lowest in the nation.)



CALIFORNIA ANTITRUST ACTION AGAINST AMA

JOHN L. MOORE, JR., *Atlanta**

ON MARCH 1, 1970, United Medical Laboratories, Inc. filed suit against the American Medical Association, the College of American Pathologists, the American Society of Clinical Pathologists, the California Medical Association, California Blue Shield, and the local medical societies in the State of California. The suit is brought under the Federal Antitrust Statutes, seeking damages and injunctive relief.

The petition filed in the United States District Court for the Northern District of California in San Francisco, alleges that the plaintiff United Medical Laboratories, Inc. is the largest commercial laboratory in the United States. The petition also states that its annual gross sales are now in excess of \$20,000,000. According to the petition, United provides laboratory services at low costs to practicing physicians through the use of the mails. The practicing physician collects, handles, and packages a given specimen. He then forwards the specimen to United's commercial laboratory in Portland, Oregon. The laboratory performs the requested clinical tests on the specimen and advises the physician of the results. United then bills the physician for the services provided. United alleges that because of its size it can provide these services at a lower cost than the physician can provide them in his own laboratory.

Competition

United alleges that pathologists in the AMA, the California Medical Association, the College of American Pathologists, and the American Society of Clinical Pathologists are in direct competition with United. United says that a substantial portion of the services performed by individual pathologists are in connection with clinical, or chemical pathology, as compared to analytical pathology. United says that, according to its best information and belief, the most profitable portion of business engaged in by pathologists is clinical pathology. United says that analytical pathology, concerned with analysis of living tissues, is a less profitable end of pathology. In any event, United alleges that the competition between it and the defendants relates to clinical pathology and not analytical pathology in which United does not engage.

Offenses Charged

United alleges that pathologists have been concerned in the last decade with the threat of commercial laboratories providing clinical testing more efficiently and at a lower cost than pathologists. According to United, there developed two prin-

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

cial avenues employed by the pathologists to curtail the competitive threat presented. First, there was an advertising and publicity campaign to develop the public image that the use of a commercial laboratory could be hazardous and risky. In addition, it is alleged that the pathologists employed other pressures such as the removal or threat of removal of hospital privileges to physicians using commercial laboratories. Finally, there is the alleged development of AMA policy declarations of ethical conduct to promote the concept that it was against good medical practice for a physician employing a commercial laboratory to include the bill of the commercial laboratory in the bill sent to the patient. According to United, the AMA indicated that the laboratory bill should be sent directly to the patient. In any event, the AMA had indicated that the referring physician's bill should have a separate item for the disbursement for the charge paid to the laboratory. United then alleges that all of these indicated the development of a policy of a "double standard to facilitate the retention of excessive profits by pathologists."

Suit by Department of Justice

The petition next recites the facts of the suit by the United States against pathologists leading to a consent decree in the United States District Court in Chicago in June, 1969. The petition goes on to allege that the defendants have refrained from asserting the more direct pressures prohibited by the Chicago consent decree but that they have engaged in an extensive campaign calculated and intended to have a coercive effect against physicians who might otherwise employ United's services. United says that pathologists have advised physicians that they are ethically bound not to take a markup, commission, or profit on services rendered by others, except when those others were employed by physicians. However, according to United, pathologists and physicians employing laboratory personnel were not advised that they were ethically precluded from profiting on services performed by technicians employed by them.

There is a further complicated allegation that the defendants have conspired with respect to the indigent health services program called "Medi-Cal." Apparently, California pays for Medi-Cal services under the Relative Value Studies schedules. The Relative Value Studies have been revised to divide into two procedures the collecting of the specimen and actually doing the chemical analysis of the specimen. The procedure of collecting the specimen has been priced very low so that a physician who wants to use United's services cannot be sufficiently compensated. In addition, the Medi-Cal program requires a separate statement from the United laboratory for its portion of the services. The petition alleges that this amounts to a dual pricing system permitting the allowance of claims to pathologists or physicians employing laboratory personnel at a higher rate and for higher profits than allowed when the same claim is made by a physician acting through a commercial laboratory. On a particular procedure United alleges that a group test performed by a pathologist laboratory would receive \$29, while the same procedures would allow the commercial laboratory \$6 and \$3 to the physician for a total of \$9.

Damages

The plaintiff is unable to give the exact amount of damages but alleges that, in its best belief, it has suffered \$3,500,000 to date and that damages are continuing at the rate of in excess of \$1,500,000 a year. Based on that calculation, the plaintiff alleges that by January, 1973, its damages will amount of \$8,000,000 and accordingly asks for treble damages for a total of \$24,000,000. In addition, plaintiff asks for injunctions against all of the practices complained of in the petition.

Comment

This litigation, for the first time, raises very substantial questions concerning the right of medical societies to exercise ethical control on member physicians in any connection with charges to the patients. The consent decree of June, 1969, in the pathologists' suit in Chicago seemed to skirt around this issue. The present litigation described raises the issue directly and its resolution will be of interest to all physicians in the country.

Suite 1220

C & S Bank Building



ABSTRACTS BY GEORGIA AUTHORS

Rasmussen, W. A., M.D., and Lisella, F. S., M.P.H., Georgia Dept. of Public Health, 47 Trinity Avenue, Atlanta, Ga. "Converting a Compact Station Wagon to a Mobile Health Unit," Public Health Reports 84:71-76 (Jan.) 1969.

Seeking practical public health tools to reach the low socio-economic groups with health services often involves the use of mobile clinics. However, previous mobile clinic programs have frequently encountered overwhelming technical and economic problems.

This paper describes conversion of compact station wagons (90 to 108 inch wheel base) to a simple, highly mobile and economical curbside health unit. These vehicles used for immunization, tuberculin testing, blood testing for syphilis, chronic disease screening, and family planning programs.

The curbside unit can be used by simply removing the middle of the three benches and replacing it with a card table and folding chair. An expanding top on the station wagon permits convenience of full head room.

It was the authors' conclusion that these curbside vehicles have provided an appropriate response to public health programs, reaching many who otherwise would have remained unserved.

Moody, Max D., and Webb, C. Douglas, Jr., NCDC, Atlanta, Ga. 30333, "Identification of Group-A Streptococci by Direct Fluorometry," Applied Microbiology, 7:627-633 (April) 1969.

A simple direct fluorometric method for rapid identification of group A streptococci is described. The method permits the detection of the organism in mixed cultures without the aid of a microscope and is amenable to automated processing of specimens. Experience with the indirect fluorometric method revealed that nontrypsinized cells from

a 10-fold dilution of overnight broth cultures could be stained with uniform brilliance with fluorescent antibody (1:15 dilution) and that fluorescent antibody dissociated from such cells at 55 C for 20 min gave serologically specific fluorometric values. With this information, it was possible to develop a simpler fluorometric test which gave results comparable to those obtained by conventional cultural-precipitin grouping techniques. In the direct test described, cultures from throat swabs were incubated overnight, and cells from a 10-fold dilution were stained with specific fluorescent antibody (1:50 dilution) and then rinsed. The stained specimens were transferred to a continuous-filter paper strip (Whatman 3 MM) and read serially in a Turner 110 fluorometer with Corning 5840 and Wratten 2A filters in place. The reagents used required careful standardization and testing to assure that fluorometric readings above a specified value would be indicative of the presence of group A streptococci.

Birge, Jack E., M.D., The Carrollton Clinic, Carrollton, Ga. "Prolonged Intraperitoneal Retention of an IUD Uterine Perforation," Abdominal Surgery, 12:78-80 (May), 1970.

The incidence of perforation of the uterus by an IUD will undoubtedly increase as the device becomes more popular and the corresponding incidence of its use increases. A case is reviewed where an open coil IUD gained entrance into the intraperitoneal cavity after uterine perforation probably beginning at the time of insertion. The device was retained intraperitoneally for some three years producing no immediate complications of hemorrhage or infection and no significant late complications. Repeated episodes of lancinating abdominal pain led to its discovery. Upon removal, the only intraperitoneal reaction noted was a

minimum of adhesions. No other case was found in reviewing the literature where an IUD had been retained in the intraperitoneal cavity for as long as the 3½ years duration. Conclusions are that all IUD's gaining entrance into intraperitoneal cavity should be removed. Closed type IUD's produce a high incidence of intestinal obstruction and immediate removal is mandatory. The open type IUD will undoubtedly be symptomatic until removal, but produce little intraperitoneal foreign body reaction and apparently little danger of complications. Therefore, should other medical problems deem immediate surgery inadvisable, delay of removal until a more opportune time poses no significant increase in risk to the patient, providing complications of hemorrhage and infection have not occurred.

Nelson, George H., M.D., Ph.D., Medical College of Georgia, Augusta, Ga. 30902, "Patterns of Maternal Urinary Estriol Excretion in Stillbirths and Neonatal Deaths," S. Med. J., 62:1685-1689 (Sept.), 1969.

Excretion patterns of maternal urinary estriol have been reported in 14 pregnancies which ultimately terminated in stillbirth or neonatal death. In 10 of the 14 cases the urinary estriol excretion was low and correlated well with fetal jeopardy. In two of the other cases the time between urine collection and fetal death was too long for the estriol determination to have reflected impending fetal death. In one case a urine collection two days before fetal death showed high estriol and one can only surmise that something acute happened in this pregnancy. In one case death was due to a pneumothorax in the neonatal period and one would not expect antepartum estriol determinations to have reflected this catastrophe.

THE ASSOCIATION



NEW MEMBERS

Borders, Juel P., M.D. Active—Fulton—OBG	759 Hunter Street, N.W. Atlanta, Georgia 30314
Collins, William C. Active—Fulton—Or	275 Carpenter Dr., N.E. Atlanta, Georgia 30328
Cortes, Julio P. Active—Fulton—Anes	401 Peachtree Street, N.E. Atlanta, Georgia 30308
Del Rio, Gabriel G. Active—Georgia Medical —Pd	P. O. Box 6688 Savannah, Georgia 31405
Haddad, Michel N. Active—Fulton—Path	765 Woodruff Building Atlanta, Georgia 30322
Hayes, Thomas E. Active—Walker-Catoosa- Dade—Su	711 Medical Arts Chattanooga, Tennessee 37404
James, Floyd DE-2—Fulton—Path	1968 Peachtree Rd., N.W. Atlanta, Georgia 30309
Lin, Hui-Ching Y. Associate—Fulton—I	634 Wilson Rd., N.W. Atlanta, Georgia 30318
Maloney, George R. Active—Fulton—U	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Michaels, John Active—DeKalb—Pd	2100 Park Lake Dr., N.E. Atlanta, Georgia 30329
Mitchell, P. Robert Active—Cobb—OBG	110 Lewis Dr., N.E. Marietta, Georgia 30060
Page, John A. Active—Bibb—OPH	740 Hemlock Street Macon, Georgia 31201
Tamayo, Pedro L. Active—Baldwin—OR	Box 714 Milledgeville, Georgia 31061

SOCIETIES

The **DeKalb County Medical Society** has presented copies of *Today's Health Guide* to all of the high schools in DeKalb County, in an effort to encourage more young people to consider careers in medicine.

Hall County Medical Society has donated \$500 to the Northeast Georgia Speech and Hearing Center for the purchase of a portable audiometer, an instrument for testing hearing.

PERSONALS

First District

James C. Metts, Jr., chairman of Savannah's Community Cardiovascular Council, testified in June before a Congressional committee in Washington, D.C., in defense of local heart disease and stroke control programs.

Alton Williams was guest speaker for the annual Brewton Parker College Alumni Banquet in May.

Second District

John J. Collins, Jr., son of Dr. Collins of Thomasville, has been appointed as Director, Division of Thoracic and Cardiac Surgery, in the Department of Surgery of Harvard Medical School at the Peter Bent Brigham Hospital, Boston, Mass.

Fourth District

Francisco Macias has moved his office from Griffin to Hampton, becoming the second doctor in that town.

Fifth District

John T. Godwin has been elected president of the Health Careers Council of Georgia, Inc.

William Hopkins spoke on the problems of drug abuse in the nation to approximately 500 Cedartown youth, parents and educators at a Drug Abuse Seminar in April. The seminar was held at Cedartown's Northside School.

James H. Larose addressed the Mobile County Medical Society on "Clinical Nuclear Medicine Today," in May.

Alfred A. Messer has just published *The Individual in His Family*, through Charles C Thomas, Publisher, Springfield, Ill.

Sixth District

Charles T. Rumble, former medical director of Macon Hospital, has opened an office for the practice of pediatrics at his residence in Macon.

Ninth District

Ralph Bottoms moved his practice from Cumming to Blairsville in May.

DEATHS

John Fabian Busch

John Fabian Busch, 68, died May 6 at Kennestone Hospital in Marietta following a brief illness.

Longtime assistant chief of the Department of Medicine and Surgery for the Veterans Administration in Washington, he came to Atlanta as assistant director of TB Control, Georgia Department of Health. Dr. Busch joined the Veterans Administration in 1946 and held his position there until his retirement in 1965.

He is survived by his widow, the former Bruce Lipscomb; sister, Mrs. B. Courtney McLean of Aiken, S.C.; stepson, Garvin M. Moore, Jr., of Bedford, Mass.; grandson, Jay Moore of Bedford; aunt, Mrs. James F. Byrnes of Columbia, S.C., and nephew, Maj. Richard T. Mattison, USAF, Kadena, Okinawa.

Thomas J. Ferrell, Sr.

Thomas J. Ferrell, Sr., died suddenly May 29 while visiting in Highlands, N.C.

He was graduated from Mercer University and the Medical College of Georgia. He settled in Waycross as physician with the old Atlantic Coast Line Railroad Company hospital, and later established private practice.

Dr. Ferrell was a member of First Presbyterian Church and served as an elder. He was a former vice-

president of the Medical Association of Georgia and president of the Ware County Medical Society.

He was a former president of the Memorial Hospital Staff and served at one time as chairman of the Ware County Board of Health. He had served on the Waycross Board of Education for several terms.

Dr. Ferrell is survived by his widow, the former Flora Conoly of Waycross; a daughter, Mrs. William McClarin, and two sons, T. J. Ferrell, Jr., M.D., and Will Ferrell.



Noah D. Meadows, Jr., M.D., of Marietta, recipient of the MAG Civic Endeavor Award.

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THE MONTH IN WASHINGTON

The American Medical Association urged that Congress appropriate as much money as possible for medical education to help "meet the pressing need which exists today for an increased number of physicians."

Testifying before a House appropriations subcommittee, Dr. C. H. William Ruhe, director of the AMA's Division of Medical Education, said the association recognized the need for an overall reduction in federal spending to combat inflation.

"In view of this," he said, "we believe that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need that exists at this period in our history for more physicians, we urged that appropriations relevant to the production of physicians be given first priority."

Dr. Ruhe pointed out that funds had not been appropriated for a backlog of approved applications for construction of facilities for new medical schools and expansion of existing schools as authorized by the Health Professions Education Assistance Act, the Health Research Facilities Construction Act and the Medical Library Act. He also said that full funding in the amounts authorized by the Health Manpower Act of 1968 is necessary to permit construction of new and expanded facilities before major enrollment increases in medical schools will be feasible.

Incentive for Expansion

"The provision in the Administration budget of funds for the Physician Augmentation Program and for special improvement grants has been a considerable incentive to medical schools to expand enrollments," Dr. Ruhe said, "but many schools have already increased their enrollments to full capacity in their existing facilities. Others have been in serious financial distress and are in desperate need of increased operational support to maintain their present enrollments or even to survive. It must be recognized that such schools will need further facilities and operating funds which are necessarily tied to increased enrollments."

The subcommittee's hearings were on appropriations for the 1971 fiscal year beginning this July 1.

Grants Announced

Using funds appropriated for the current fiscal year, 1970, the Department of Health, Education and Welfare recently announced nearly 300 grants to schools of medicine and other health professions totalling more than \$54 million.

About \$7.6 million went to 27 schools of medicine and osteopathy under the Physician Augmentation Program. A government spokesman said the grants would enable the schools to increase their first year enrollment by 395 students.



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About \$46.5 million in institutional grants was allotted to 260 schools in the health professions—medicine, dentistry, osteopathy, podiatry, optometry, pharmacy and veterinary medicine. These funds also will enable the schools to add more students through purchase of new teaching equipment, improvement of the physical teaching environment, purchase of supplies, books and periodicals, and other expenditures to improve the education of students.

AMA Supports RMP

The American Medical Association supports extensions of the Regional Medical Programs and, with some reservations, the program for Comprehensive Health Planning and Public Health Services.

Testifying before a House Public Health and Welfare Subcommittee, Dr. Bland W. Cannon, Memphis, Tenn., a member of the AMA's Council on Medical Education, emphasized that the AMA believes that RMP "should continue as a program of continuing medical education, with patient care being limited to demonstrations as an adjunct of the education and research processes."

He said the AMA opposes legislation that would combine the individual programs.

"These programs are relatively new and we believe should be evaluated, as well as allowed to develop further evidence of their individual strengths and weaknesses," he said.

Dr. Cannon pointed out that the AMA House of Delegates last December affirmed its support of the concept of Regional Medical Programs and urged

AMA members to participate at all levels in giving guidance to implementing the programs.

Broadening Program Scope

The AMA supports broadening the scope of the programs to include "other major diseases," in addition to heart disease, cancer and stroke, he said.

He said a combination of the programs would result in a change toward emphasis on patient care in RMP.

"We would view with grave concern any attempt to change this essentially educational program to a program for the provision of health services," Dr. Cannon said. "The medical profession today generally views RMP as a means of aiding the physician to provide better care to his patients. It is this attitude which has brought about the outstanding cooperation between practicing physicians and RMP and which has been a major cause of success for the program thus far. If RMP returns to an earlier concept of providing services to the patient, rather than its present goal of assisting the individual physician to treat the patient more effectively, this cooperation will, in many cases, be lost. The program's beneficial accomplishments will then be diminished."

Support of Legislation

The American Medical Association supports in general, legislation (S. 3835) that would provide a comprehensive federal program for the prevention and treatment of alcohol abuse and alcoholism.

Dr. Marvin A. Block, Buffalo, N.Y., a member of the AMA's Committee on Alcoholism and Drug Dependence, termed the measure "a major landmark in public policy" in the field.

"It sets forth the proposition that alcoholism is an illness which can and should be treated, and it commits national resources to the establishment and coordination of facilities necessary for treatment and rehabilitation," he said at a hearing of the Senate Subcommittee on Alcoholism and Narcotics. "We are in general agreement with this legislation."

Institute for Treatment

The bill would establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism. The Health, Education and Welfare Secretary, acting through the institute, would be required to submit within one year a detailed federal program, develop model programs for states, and conduct research and educational programs. Federal grants would be authorized for prevention, treatment and rehabilitation facilities and programs at the state and local level.

Dr. Block specifically favored several of the bill's provisions, including one that treatment and control programs should be community based, whenever possible.

"Insofar as it is feasible and economically sound, most alcoholics should be treated in their own communities and not be relegated to a distant centralized institution for treatment," he said.

Need Questioned

But the AMA spokesman questioned some other provisions. He saw no need for a new institute. He said the present National Center for Prevention and



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WASHINGTON / Continued

Control of Alcoholism could perform the proposed institute's duties and responsibilities.

He said the AMA also questions whether alcoholics should be made eligible for welfare cash benefits and for health care under other government programs, such as Medicare and Medicaid, on the ground that they are alcoholics.

Noting that the legislation is concerned mainly with operation of programs by public and voluntary agencies, Dr. Block said:

"We should not overlook, however, the role that the private physician has played, and can play, in this important area. More and more, the physicians of this country are facing up to the problem of alcoholism in their daily practice. They are recognizing that, as difficult as alcoholism may be, it is an illness which can be dealt with, and that they can help their patients in cooperation with other professionals in the community."

The bill was introduced by Sen. Harold E. Hughes (D., Iowa), a recovered alcoholic and chairman of the subcommittee, and 37 co-sponsoring senators.

Treatment Approved

L-dopa, a new treatment for Parkinson's disease, has been approved for general prescription use but it may be several months before it is available in ample supply.

"Clinical tests conducted during the past several years by medical researchers and two major drug firms have demonstrated the usefulness of L-dopa in the treatment of this disease which now afflicts possibly a million persons," FDA Commissioner Charles C. Edwards, M.D., said.

Benefits Outweigh Risks

Approvals were granted to applications made by Hoffmann-La Roche, Inc., and Eaton Laboratories Division of the Norwich Pharmacal Co., Norwich, New York. Both firms conducted studies in animals and humans to establish the drug's safety and effectiveness. An analysis of these studies indicated that benefits to the patient outweigh the risks involved, the FDA said.

"However, the Food and Drug Administration will require both drug firms to continue research into the drug's long-term effects and make certain it is safe and effective for long-term use," Dr. Edwards said. "This is the first time that FDA has included such a requirement in a new drug approval."

In order to give a balanced picture, Edwards pointed out that:

—Clinical studies have shown that approximately one-third of the patients receiving L-dopa do not respond favorably.

—Side effects have been reported in a majority of patients, some of them quite unpleasant and others even dangerous. Whether or not the use of this drug is justified in the very early stages of Parkinson's has not been established.

Long Term Dosage

—Since Parkinsonism is a chronic disease, patients will have to take L-dopa for long periods of time. We don't know how these patients will react after five, 10, or 15 years of treatment. Because of our limited

knowledge of the drug's long-term toxicity, it is conceivable that it could reverse the benefit to risk ratio.

The name L-dopa comes from the initials of an amino acid, levodihydroxyphenylalanine. Dr. George C. Cotzias, of the Medical Research Center, Brookhaven National Laboratory in Upton, New York, was the first to demonstrate the usefulness of L-dopa at high dosage levels. Dr. Andre Barbeau, director of the Department of Neurobiology at the Montreal Clinical Research Institute, has been studying the new drug for the past 10 years and is also credited with aiding in its development as a treatment for Parkinsonism.

Syphilis Increase

A marked increase in syphilis cases in the United States was reported by the National Communicable Disease Center for the first four months of this year.

The infectious disease jumped as much as 50 per cent or more in some areas while the nation as a whole experienced an increase to 6,861 cases from 6,203 for the same four-month period last year. One of the biggest increases was noted in New York City where 1,241 cases were reported as compared with 863 for the same period last year.

Hill-Burton Extended

Congress approved legislation extending the 24-year-old Hill-Burton federal-aid-to-hospitals program for three years with authorized expenditures of \$2.76 billion.

The final form of the legislation was a compromise agreed to by House and Senate conferees after the two branches of Congress passed differing versions.

The authorized expenditures broke down: \$1.26 billion for various state grant-in-aid programs for construction and modernization of hospitals, and \$1.5 bil-

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lion for loan guarantees. The measure also authorizes funds to subsidize interest payments on loans up to 3 per cent.

The legislation approved by the conferees followed the House version for the most part. The Senate had approved a five-year \$6.2 billion bill. The conferees eliminated entirely a Senate provision for \$750 million of direct loans for public hospitals, which was strongly opposed by the Nixon Administration.

Also knocked out was a Senate amendment for a new formula for allocation of federal funds in a way that would have benefited large industrial states. However, the Health, Education and Welfare Department was directed to make a study of possible formula changes and report to Congress in two years.

New Appointments

Two physicians and a management expert were appointed Deputy Assistant Secretaries for Health, three long-vacant posts in the Department of Health, Education and Welfare.

The appointees are:

—Dr. Thomas C. Points, Oklahoma City, Okla., for Health Services. He is an alternate in the AMA House of Delegates and on the AMA Council on Health Manpower. As director of the Department of Preventive Medicine at the University of Oklahoma Medical Center, he helped establish the state's rural health project, "Project Responsibility."

—Dr. LeRoy A. Pesch, Buffalo, N.Y., for Health Manpower. He was dean of the School of Medicine at the State University of New York at Buffalo.

—Gerald Riso, New York City, formerly with Booz Allen and Hamilton, Inc., management consultants, for Policy Implementation.

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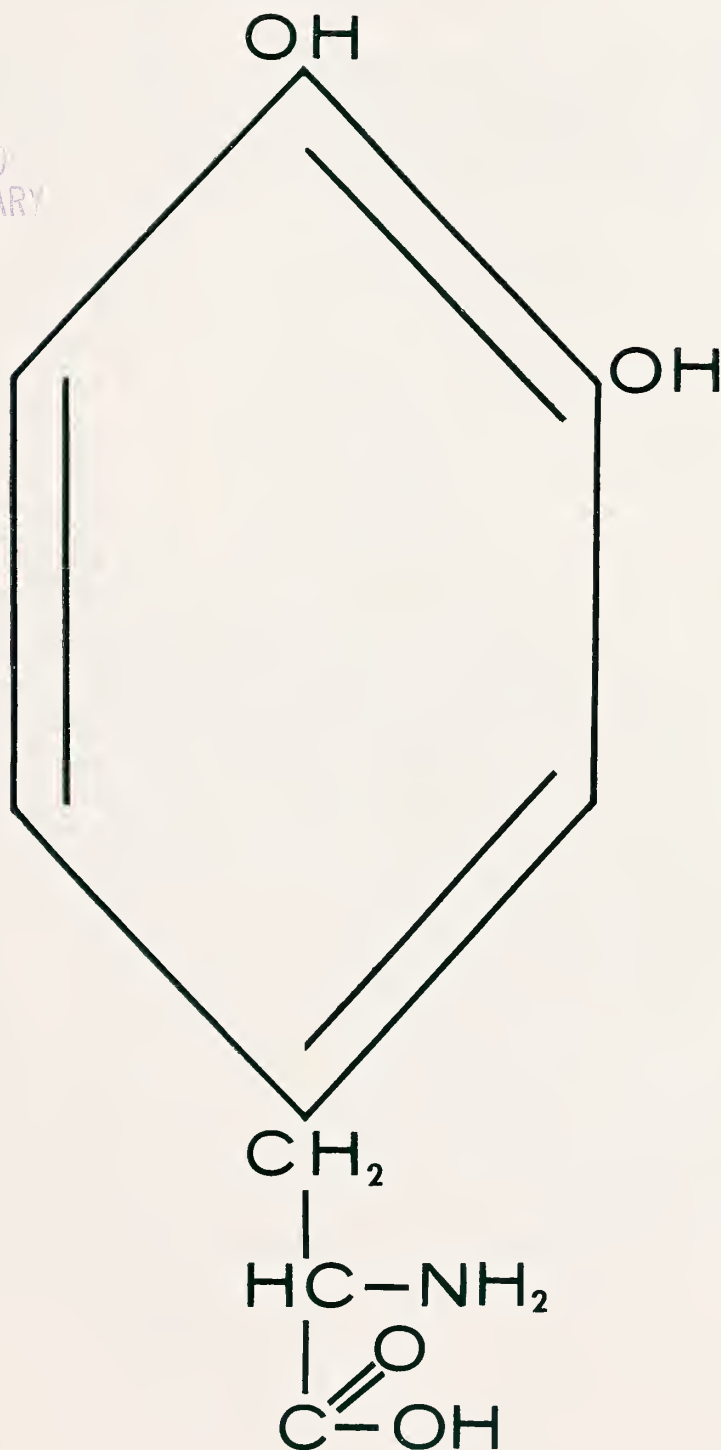
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Contents

Medical College of Georgia
Medical Grand Rounds

GRAVES' DISEASE, GASTROINTESTINAL DYSFUNCTION, AND MUSCLE WEAKNESS	
T. E. Temple, Jr., M.D., and N. B. Watts, M.D.	313

Scientific Articles

ARTERIAL BLOOD GAS VALUES	
Thomas J. Yeh, M.D.	319
PLACENTA BILOBA IN UTERUS ARCUATUS	
Richard Torpin, M.D., and Frank C. Story, M.D.	323

Special Articles

WHO PICKS UP THE UGLY BABY?	
George R. Swerdloff, D.D.S.	325
SERVICES AVAILABLE THROUGH MAG	
J. Rhodes Haverty, M.D.	328

Editorials

RURAL HEALTH CONFERENCE SCHEDULED FOR SEPTEMBER	331
L-DOPA AND PARKINSONISM	
William H. Stuart, M.D.	331

Features

President's Letter	333
Cancer Page	335
Heart Page	337
Legal Page	339
Highlights of AMA House of Delegates Meeting	341

The Association

New Members	346
Societies	346
Personals	346
Deaths	347
Month in Washington	347

Cover

Designed by Marie Seaman.

Medical College of Georgia

Medical Grand Rounds

GRAVES' DISEASE, GASTROINTESTINAL DYSFUNCTION, AND MUSCLE WEAKNESS

T. E. TEMPLE, JR., M.D.,* and N. B. WATTS, M.D.,† *Augusta*

DR. T. E. TEMPLE, JR.: In a recent Grand Rounds, we discussed a man with severe thyrotoxicosis whose symptoms were primarily related to his heart.¹ He underwent a subtotal thyroidectomy one week after presentation at this conference, but while the operation was without incident, he became psychotic postoperatively. With appropriate therapy the psychosis resolved. The psychiatric aspects of thyroid disease are well known and have been reviewed previously.²

Today, the patient for discussion illustrates other features of Graves' disease. The fascinating, but inexplicable, differences between individuals with the same metabolic disorder are demonstrated by comparing this woman and the man discussed before. Dr. Watts will present the case.

DR. NELSON B. WATTS (Intern, Department of Medicine): A. A., a 52-year-old Caucasian female, was admitted to the Medical College of Georgia-Talmadge Memorial Hospital on July 9, 1969, for evaluation of extreme weakness, anorexia, vomiting and diarrhea. Her symptoms were most severe during the two weeks preceding admission. Approximately two months before admission her appetite decreased and the odor of food became offensive, forcing a reduction of food intake. Frequent vomiting and diarrhea (5 to 6 watery, non-bloody stools per day) plagued her. There had been no dysphagia, heartburn, abdominal pain or cramps, tenesmus, or hematemesis. A 35-pound weight loss occurred during the five weeks before admission. Weakness

progressed to inability to stand or walk without assistance and three weeks before admission she had to stop working as a clerk. She was unable to ascend steps or enter an automobile without manually raising her legs. She was unable to comb her hair because her arms fatigued quickly when raised.

Past history and review of systems were unrevealing except for a vague history of right upper quadrant fullness, diagnosed as gallbladder disease, and intermittent joint pain, without swelling or redness, involving the distal interphalangeal joints, knees and back, diagnosed as degenerative arthritis. Family history revealed an overweight sister with an unknown type of thyroid disorder.

Admission Physical Examination

Blood pressure 160/70 mm Hg; Pulse 104 per minute and regular; respirations 20 per minute; weight 79.5 kg., temperature 37°C. (98.6°F.). General appearance was that of middle-aged, overweight, agitated female with warm, dry skin. The hair was thin and fine. The eyes exhibited a prominent stare and lid lag but no exophthalmos. The extraocular muscle movements were normal and no nystagmus was seen. Continued upward gaze produced fatigue of the levator palpebrae. Funduscopic examination of the retinae was normal. Her ears, nose, and throat were normal. Carotid artery pulses were easily palpated and quite forceful; there was no jugular venous distention. The thyroid gland was diffusely enlarged, firm and non-nodular, with an estimated weight of 90 grams. A systolic bruit was heard over the entire gland. Small, non-tender nodes were palpable in the axillae and inguinal areas. The chest and breast examinations were normal. The heart was hyperactive

* Assistant Professor of Medicine, Section of Clinical Endocrinology and Metabolism.

† Intern, Department of Medicine.

These conferences are taped weekly and are selected and edited by Joseph P. Bailey, Jr., M.D., Professor of Medicine, Medical College of Georgia. The participants are principally faculty and house staff of the Department of Medicine, or Junior Medical Students assigned to the patients. Members of other departments are so identified.

DISEASE / Temple, Watts

with the point of maximal impulse in the fifth left intercostal space at the mid-clavicular line. The rhythm was regular and the intensity of first and second heart sounds was increased. No third or fourth sounds were heard. A grade 3/6 systolic ejection murmur was heard over the entire precordium but was loudest in the third intercostal space adjacent to the sternum. It did not radiate to the carotid arteries. The abdomen was rotund without tenderness. Bowel sounds were hyperactive. The liver, spleen and kidneys were not palpable. Mid-epigastric pulsations of the aorta were easily identified. Pelvic and rectal examinations were unremarkable. Examination of the arms and legs revealed severe proximal muscle weakness. No edema, skin lesions or clubbing was found. Neurologic evaluation demonstrated hyperactive deep tendon reflexes with very rapid relaxation. There was a rapid fine tremor of the hands and extended fingers. All cranial nerve and cerebellar functions were intact. Sensory examination was normal.

Laboratory Data

Admission CBC was normal. Urinalysis revealed only 2+ protein. The following chemical data were obtained: serum cholesterol, 79 milligrams per 100 ml.; SGOT, 75 (normal 5-40 U/ml.); SGPT, 75 (normal 0-35 U/ml.); LDH, 474 (normal 200-500 U/ml.); total bilirubin 0.5 milligram per 100 ml. with direct bilirubin of 0.05 milligram per 100 ml.; serum calcium, 9.8 mg.; inorganic phosphate, 4.7 mg.; serum uric acid, 5.0 mg.; creatinine, 0.5 mg.; BUN, 16 mg.; serum creatine phosphokinase activity, 12.8 units per ml. (normal 0 to 25 units in females); protein bound iodine, 18.7 μ g.; serum thyroxine (by column chromatography), 12.9 μ g. (normal 2.9-6.4 μ g.); total urinary creatinine, 580 mg. with 54 mg. of creatine; thyroid uptake of ¹³¹I at 6 hours, 50.9 per cent, and at 24 hours was 52.6 per cent. An electrocardiogram revealed sinus rhythm; rate of 98 beats per minute; tall, peaked P waves in leads II, III, and aVF; and low T waves in all leads. Chest x-ray showed degenerative arthritis of the dorsal spine but no cardiac or pulmonary abnormalities.

Hospital Course

The clinical diagnosis of severe Graves' disease was made upon admission and subsequently confirmed by the laboratory data. With suppression of nausea by Compazine (prochlorperazine), a clear liquid diet was accepted and tolerated by the patient. Oral reserpine was administered to allay the peripheral thyrotoxic manifestations. The patient improved rapidly and four days after admission 8

millicuries of ¹³¹I was administered by mouth as primary treatment. Twenty-four hours after the dose of ¹³¹I treatment with Tapazole (methimazole) 40 mg. every eight hours was begun. During the hospital stay, she progressively improved. Her serum enzymes returned to normal and serum cholesterol increased to 111 mg. per 100 ml. She was discharged with directions to continue the Tapazole, 10 mg. every eight hours, for two months. She is to be re-examined in the Clinic.

DR. T. E. TEMPLE, JR. (Assistant Professor of Medicine, Section of Clinical Endocrinology and Metabolism): Let's begin the discussion with some points about the gastrointestinal aspects of the case and then summarize the thyrotoxic neuromuscular disorder so well demonstrated by this patient. Admission was precipitated because of persistent, watery, non-bloody diarrhea and vomiting of approximately two weeks duration. In addition she had been anorexic for two months and had lost 35 pounds of weight. Weight loss is a very common feature of hyperthyroidism, so common that many physicians do not strongly consider the diagnosis unless some decrease in weight has occurred. Anorexia, on the other hand, is an uncommon symptom of Graves' disease. It probably contributed significantly to the weight loss in this patient though the catabolic effects of excess thyroid hormone, even when the usually found hyperphagia is present, are well documented. Anorexia is reported to be more common in older hyperthyroid patients³ and our patient is middle-aged. Scarf⁴ in 1936 reported a 20 per cent incidence of anorexia in a series of 80 hyperthyroid patients. This incidence exceeds that observed by most physicians today and far exceeds that which I have found. This probably reflects earlier visitation to a physician than previously. The vomiting experienced by our patient is another uncommon feature of Graves' disease, though not unrecognized. Nausea and vomiting along with diarrhea may herald the onset of thyrotoxic crisis.⁵ The absence of fever in this patient is a point against crisis. Nevertheless, these symptoms are suggestive of extremely severe hyperthyroidism.^{4, 6} The presence of nausea, vomiting and anorexia should make one consider hypercalcemia, but constipation rather than diarrhea usually occurs with hypercalcemia. Hypercalcemia in thyrotoxicosis was observed in three patients reported by Stanley⁷ and has been reported by others as well.^{8, 9} Serum calcium was normal on several determinations in our patient.

Symptoms of Hyperthyroidism

Increased bowel activity is another common symptom of hyperthyroidism.¹⁰ Most often this is discovered in a careful discussion of symptoms with the pa-

tient who recalls an increase from one stool or less per day to two or more. Though Bockus³ states an incidence of 25 per cent in hyperthyroidism, diarrhea of the type suffered by our patient is rarely reported,¹⁰ and has been unusual in my experience. In 1932, Shirer¹¹ first called attention to rapid intestinal transit during barium studies of the small and large bowel of hyperthyroid subjects. Of 42 patients, only one exhibited persistent diarrhea and two others, intermittent diarrhea.

Studies of gastric function in hyperthyroidism have been confusing. Augmented motor activity of the stomach can be produced by feeding thyroid hormone to dogs,⁷ but in man, some observers have found delayed¹² while others have found accelerated¹³ gastric emptying in spontaneous or induced hyperthyroidism. Most clinicians believe that rapid gastric emptying occurs in man. Many observers explain abnormalities of glucose tolerance on this phenomenon with the associated enhancement of glucose absorption. However, Holdsworth and Besser¹⁴ examined the serum insulin response to an oral glucose load in 12 hyperthyroid patients. Their data indicates that, even when the blood sugar is normal, the plasma insulin is elevated. With oral glucose, an accentuated rise in plasma insulin occurred. With control of the hyperthyroidism, the serum insulin returned to expected normal levels. They interpret this as indicating a degree of insulin resistance produced by the thyrotoxic state. Woeber, et al.¹⁵ have demonstrated an impairment of insulin release in hyperthyroidism but this does not explain the elevated basal insulin levels found by Holdsworth and Besser. It would be interesting to know the results of intravenous glucose tolerance tests in their patients¹⁴ since previous data¹⁶ has indicated a normal response in hyperthyroid subjects. Because our patient had been starving for the two weeks before admission, a glucose tolerance test was not considered worthwhile.

Secretion Deficit

Gastric secretion of acid has been found deficient in 35 per cent of one collected series of 498 hyperthyroid patients.⁷ Histamine stimulation failed to decrease this incidence. Bock and Witts,¹⁷ however, using the augmented histamine stimulation test, found only one achlorhydric patient in 47 with active thyrotoxicosis. Atrophic gastritis was found in three of their 29 patients submitted to biopsy.

It is known that increased fecal excretion of calcium and phosphorus occurs in hyperthyroidism.¹⁸ The mechanism for this is not clear, though steatorrhea may be causally related. This abnormality has been shown recently to be more frequent in hyperthyroidism.^{18, 19} Steatorrhea may have been

present in our patient since on careful questioning there was a suggestive history that the formed elements in her stools tended to float. Unfortunately, a Sudan III stain of a stool smear was not made nor were other methods of assessment for fat absorption utilized. The occurrence of steatorrhea and its potential effect on Vitamin D absorption may explain why we do not observe hypercalcemia more often at this hospital. Bockus³ has stated that hypercalcemia is frequently reported in hyperthyroidism.

Dysphagia with hyperthyroidism may occur in the presence or absence of a large goiter. Since neuromuscular dysfunction²⁰ might explain this symptom, I shall defer comment about the mechanisms of dysphagia until later.

Deranged Hepatic Function

Elevation of the serum glutamic oxalacetic (SGOT) and pyruvic transaminase (SGPT), a high normal serum lactic dehydrogenase (LDH), and a low serum cholesterol were found in our patient. Her bilirubin was normal. When derangement of hepatic function occurs in hyperthyroidism, it has been considered a result of hepatic congestion secondary to heart failure. In the absence of heart failure, Bockus³ states that deranged hepatic function is rare except in the poorly nourished patient. Since poor nutrition may produce a fatty liver, one might speculate that this was occurring in our patient. This seems most unlikely to have happened in such a brief time. For many years, deterioration of hepatocellular function has been considered an early sign of thyrotoxic crisis. Excess thyroid hormone was believed to cause these changes. However, examination of the data from these early reports reveals the presence of potentially detrimental multiple nutritional deficiencies, thus confusing the issue somewhat. Jaundice in hyperthyroid patients in the absence of heart failure has been reported,²¹ but despite an elevated SGOT the serum bilirubin was normal. If only the SGOT had been found to be increased in our patient, one might avoid consideration of hepatocellular dysfunction by assigning this abnormality to the muscle disease. She did have increased SGPT levels as well. While one cannot be certain that thyroid hormone excess causes a toxic hepatitis, there is little doubt that an unfavorable prognosis appears when infectious hepatitis occurs in a patient with uncontrolled hyperthyroidism or vice versa. I have cared for three such patients, two of whom died of rapidly progressive hepatocellular failure despite intensive treatment for the thyroid disease and attempted support of hepatic function.

Low serum cholesterol is a common feature of hyperthyroidism. With the availability in the last

two decades of more direct tests of thyroid function, the serum cholesterol, along with the basal metabolic rate, has been relegated to infrequent diagnostic use. While the PBI, thyroxine, and ^{131}I studies do correlate more closely with thyroid hyperfunction than does the serum cholesterol, I still like to obtain the cholesterol as an assessment of the peripheral effects of thyroid hormone.

In considering the thyroid function tests, several items should be mentioned. The almost exact 6-hour and 24-hour concentrations of radioiodine in the thyroid point out again the usefulness of obtaining 6 hour studies. A 24-hour ^{131}I uptake of 52 per cent may not indicate severe Graves' disease, but when compared with a 6-hour uptake of 51 per cent one realizes that this patient's goiter is strikingly hyperactive. She is simply incorporating the isotope into and secreting hormone very rapidly from the thyroid. Thus, the isotope isn't available in the thyroidal iodide pool for counting at 24 hours.

Discrepancy

There is a discrepancy between the PBI of 18 mcg. and the serum thyroxine of 12 mcg. This suggests that part of what is being measured as PBI may be mono- or diiodotyrosine which have no hormonal activity but are bound to the thyroid binding proteins. The appearance of these hormone precursors in the blood occurs in patients with severe forms of Graves' disease. In addition, this discrepancy may indicate the presence of increased quantities of triiodothyronine (T_3). T_3 , however, is poorly bound to the thyroid hormone binding proteins and thus does not contribute significantly to the PBI. Sterling, et al.,²² have recently reported measurement of T_3 in human serum and correlated this with the disease state. Their study suggests that some patients with Graves' disease oversecrete this hormone in the presence of minimal or no hypersecretion of thyroxine. This finding may explain the observation of a normal PBI in 10 to 15 per cent of most series of patients with Graves' disease.

The other major manifestations of hyperthyroidism demonstrated by our patient was extreme muscle weakness. This may be confusing at times since several disorders of skeletal muscle have been described in association with thyrotoxicosis.²³ Both myasthenia gravis²⁴ and periodic paralysis²⁵ occur with Graves' disease in a greater than expected percentage of patients. They are relatively rare, however, in comparison to true thyrotoxic myopathy. This lesion is not a new one. It was described by Bathurst²⁶ in 1895. Though considered rare for a

period of years, it is known now to be present at least in mild form in 80 to 90 per cent of most cases of hyperthyroidism. Clinically one can find some evidence of myopathy in 90 per cent of patients.²⁷ When one adds electromyography to the evaluation, about 90 per cent of patients will demonstrate diagnostic features. Nor is it necessary to distinguish between acute and chronic thyrotoxic myopathy. If the acute variety does exist as a distinct entity, it is difficult to distinguish clinically or histologically. More likely the acute variety represents sudden exacerbation of weakness such as that observed three to four weeks before our patient was admitted. The history we obtained at the bedside is slightly different from that presented and suggested muscle weakness for four to six months before admission. Careful analysis of historical information suggests, at least to me, that separation of acute and chronic thyrotoxic myopathy serves only to confuse the issue.

Muscle Weakness

Why certain patients develop muscle weakness and others do not, I don't know. The more severely thyrotoxic patients appear to have the most weakness and atrophy.²³ It is most easily observed in previously muscular men but, as with our patient, women demonstrate this by inability to perform their regular daily activities. She was unable to climb a small stepladder in her work as a clerk, unable to raise her arms sufficiently to comb her hair, and unable to raise upward even slightly from the squatting position. When a patient presents with this much trouble, the physician must initiate therapy immediately. Frequently, this is almost a manifestation of thyroid crisis.

The metabolic changes in the muscle in thyrotoxicosis have been lucidly reviewed by Peter.²⁸ Yet to date, no definite answer as to the causative factors have appeared. One consistent chemical finding has been an increase in mitochondrial protein per gram of muscle. Another finding is an increase in sacrotubular protein. Both of these findings are offered as an explanation for the accelerated muscle contraction observed in testing of reflexes of thyrotoxic patients. Neither explains the muscular weakness. Danowski, et al.,²³ have suggested that the total body negative balance of protein and electrolytes may be important. Nutritional deficiency²³ is also of some importance. It will accentuate the catabolic effect of excessive thyroid hormone. The dietary and gastrointestinal history reviewed above is certainly consistent with vitamin and essential food deficits. Pyridoxine deficiency²⁹ has been documented in hyperthyroidism. Perhaps muscular dysfunction may have contributed to her

gastrointestinal problems. Fischer, et al.,²⁰ have demonstrated in one patient with apathetic hyperthyroidism significant disturbance of esophageal motility. Their patient had dysphagia and 40 per cent spontaneous wave activity. As far as one can determine, this affects only the upper two-thirds of the esophagus where there is striated muscle. I am unaware of any smooth muscle involvement in thyrotoxicosis.

Harvard, et al.,²⁷ have correlated the electromyographic (EMG) and histological changes in thyrotoxic myopathy. In their patients, muscular weakness was a primary complaint in only 6 per cent but some weakness had been observed by 34 per cent. As mentioned, muscle weakness could be elicited in 80 per cent. Structural changes were microscopically unimpressive in muscle fibers. With intravital stains, however, abnormalities were seen in 77 per cent of terminal axons and myoneural junctions. These changes are not totally specific for thyrotoxicosis having been observed in other diseases.²⁷

From a diagnostic standpoint, I am unaware of any consistently useful chemical test for the myopathy. Increased serum and urinary creatine are common in thyrotoxic myopathy.²³ They are also increased in other muscle wasting diseases.³⁰ The serum glutamic oxalacetic transaminase (SGOT) was elevated in this patient. Of course, hepatic changes may have caused this but some muscle diseases also elevate the SGOT.³¹ Satoyoshi, et al.,³² studied a large series of patients with thyrotoxic myopathy for enzyme changes. While they comment that SGOT was not increased, perusal of their data suggests that one could observe an increase up to 25 units above the usual normal levels. Lactic dehydrogenase (LDH) was not elevated in these patients. Creatine phosphokinase (CPK) was significantly increased. The CPK in our patient was within the normal range. The EMG only imperfectly correlates with the physical findings of muscle weakness.²⁷ Apparently the EMG is more sensitive since abnormalities in it have been observed in the absence of clinical muscle disease.²⁷

Diagnosis Consideration

When severe muscle weakness occurs or if involvement of respiratory, ocular or bulbar muscles occurs, one must consider myasthenia gravis. Gaan³³ has described a patient with bulbar and respiratory myopathy in chronic thyrotoxic myopathy. This is a very rare phenomenon. Diagnostically, one should do a neostigmine test if any doubt exists as to the exact pathogenesis of the patient's problem. Osserman, et al.,²⁴ have found that thyroid disease is present in 13 per cent of one series of 801 myas-

thenic patients. Of this group of 105 patients, 42 (5.3 per cent) were hyperthyroid, 46 (5.7 per cent) were hypothyroid, and 17 (2.1 per cent) had a non-toxic goiter. Therapeutically, one must attain a euthyroid state since either hyper- or hypometabolism may accentuate myasthenic symptoms.³⁴

The other metabolic myopathy so often related to hyperthyroidism is periodic paralysis.²⁵ It is indistinguishable from idiopathic periodic paralysis except for the family history and evidence of hyperthyroidism. The disease affects thyrotoxic men four times as frequently as women, at least in Japan where it has been most frequently observed. This incidence contrasts with the fact that 80 per cent of all thyrotoxicosis in Japan occurs in females. I have had the opportunity of caring for one patient with this combination of diseases. This is a lower incidence than that reported from Japan²⁵ since in one series of 432 thyrotoxic patients, 8 per cent had periodic paralysis. In contrast to myasthenia, these patients don't usually have a problem with deglutition or phonation. Hypokalemia may or may not be a part of this disorder in hyperthyroidism though it most often is. Control of hyperthyroidism appears to alleviate the paralytic episodes.

In summary, we have presented a patient with severe hyperthyroidism whose major manifestations were gastrointestinal and muscular. She has progressively improved with therapy for hyperthyroidism. Bowel dysfunction and weakness disappeared almost completely by two weeks after admission. She will be continued on Tapazole for two months after receiving her 131-I and will then have this drug stopped. She will be followed in the Clinic.

Medical College of Georgia

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HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING, JUNE 21, 1970

Finance: Referred to the next meeting of Council a statement in the amount of \$2,000 from Alston, Miller and Gaines, for legal fees in connection with the termination of MAG's suit to enjoin the Director of the State Department of Public Health from paying for drugs prescribed by Osteopaths under Medicaid. Also referred to Council a request that the Annual Sessions Committee budget be increased.

Appointments

Woman's Auxiliary Advisory Committee: S. William Clark, M.D., Waycross, appointed Chairman and Luther J. Smith, II, M.D., Columbus appointed a member.

Constitution and Bylaws Committee: Charles G. Burton, M.D., Macon.

Crippled Children's Committee: Frank R. Miller, M.D., Thomasville.

Medical Review and Negotiating Committee: H. Dale Richardson, M.D., Atlanta, member, and William W. Moore, M.D., Atlanta, alternate, representing Neurosurgery; Samuel S. Ambrose, Jr., M.D., Atlanta, member, and Tom Florence, M.D., Atlanta, alternate, representing Urology.

Committees: Combined the Committees on Emer-

gency Medical Services and Disaster Medical Care, requesting that they hold a joint meeting at the Conclave with the election of a new Chairman the first order of business. Requested Dr. Haverty to serve as convener of the Conclave meeting of the Committee on Medical Education with the election of a new Chairman the first order of business.

Insurance: Removed MAG endorsement of the Crum and Foster plan of Catastrophic Liability (umbrella) Insurance and endorsed the "TOP BRASS" plan underwritten by the St. Paul Company.

Osteopathy: Voted to request the Georgia Osteopathic Medical Association to name a Delegate and Alternate to the Committee on Review and Negotiating, and to request the Constitution and Bylaws Committee to conduct a study preliminary to permitting D.O.'s to seek membership in MAG.

Medicare: Authorized Dr. Dowda to discuss with MAG's Legal Counsel initial steps toward having MAG designated a Health Maintenance Organization should Congress adopt proposed legislation creating Part C.

Certificates of Appreciation: Voted to present Certificates to the following members retiring from the Council: Louie H. Griffin, M.D., Claxton; Lee Howard, Jr., M.D., Savannah; W. W. Osborne, M.D., Savannah.

Arterial Blood Gas Values

CLINICAL APPLICATION IN MANAGEMENT OF ACID-BASE IMBALANCE

THOMAS J. YEH, M.D.,* *Savannah*

WITH THE RAPIDLY EXPANDING medical knowledge and ever increasing life expectancy, the complexion of surgery has undergone a significant transformation during the last decade. A large number of patients who were considered too old, too ill, or too poor a surgical risk in the past are now being operated upon and the anesthesiologists are called upon to manage the most critical periods in the course of treatment. The types of surgery being performed are ever more complicated and elaborate. One needs only to look at the increasing load of thoracic surgery, vascular surgery, cardiectomy with or without extra-corporeal circulation, and organ transplantation. A good number of these cases are being done in the community hospitals.

One of the most significant advances in the management of critically ill patients is the availability of quick and reliable methods for determination of blood gases and their clinical application.

When one speaks of arterial blood gases an array of bewildering and confusing terminology such as pH, PCO₂, PO₂, base excess and buffer base comes to mind. The usual reaction is to say, "It is too complicated and confusing." Or, "It is all right for a Medical Center, but too technical and impractical for daily management of patients." Nothing can be further from the truth. I can speak with personal experience that this is a great help, and even indispensable, in the daily practice of medicine. At Memorial Medical Center of Savannah, there was equipment to determine arterial blood gases two years ago, but this was used only infrequently. We started requesting the blood gas analysis as part of the management of open heart surgery cases, but at the same time an effort was made to reorient our house staff and attending staff to think in terms of blood gases in the management of severe respiratory problems such as in multiple system injury,

over-dosage of narcotics, respiratory acidosis due to chronic obstructive emphysema and severe derangement of acid-base balance in critically ill medical patients as in diabetic acidosis, shock from various causes, low cardiac output syndrome and sustained fluid losses from intestinal fistula. Now, it is not unusual for the laboratory to receive several requests to determine blood gases; and most of these requests are not related to open heart surgery cases.

Examination of Blood Gases

Let us examine what blood gases are, what the normal values are, what the significant abnormalities are and how they help us manage our patients.

The most basic and fundamental of our bodily functions is respiration and circulation. These are the two functions anesthesiologists are entrusted upon to monitor, support and control during the following surgery.

Respiration has two distinct processes as its aim. These two processes take place usually simultaneously, but each is not dependent upon the other. They are: 1) oxygenation of blood and, 2) elimination of CO₂. Abnormalities can occur separately and their correction is not necessarily by the same means. As a matter of fact, correction of one may aggravate the situation of the other. The ultimate aim of circulation is to supply arterialized blood to the tissue level. Here, the all important factor is the tissue perfusion or micro-circulation. The blood pressure and pulse are one indication of this, but what really counts is the amount of the flow to tissue level, and its total sum, which is the "cardiac output." One must start thinking in terms of flow rather than pressure.

One can ventilate the lung, check blood pressure, pulse and venous pressure, and even monitor EKG and EEG, but how does one really know if blood is oxygenated, CO₂ is eliminated and cardiac output is adequate?

The arterial blood gases give you an indication

* From Dept. of Surgery, Memorial Medical Center, Savannah, Ga.
Presented at the meeting of the Georgia Society of Anesthesiologists,
held in conjunction with the 115th Annual Session of the Medical
Association of Georgia, Savannah.

in all these three facets: oxygenation, CO₂ elimination, and more indirectly, the adequacy of tissue perfusion as reflected by the presence or absence of metabolic acidosis.

We shall now examine how the blood gas value can help us manage the patient.

Oxygenation

The blood the tissue receives is the arterial blood which returns from the lung after it has been exposed to alveolar air. The degree of oxygenation of the arterial blood can be expressed by different means. The most readily available parameters are: 1) Blood oxygen saturation and 2) PO₂ or partial oxygen pressure.

Oxygen saturation is defined as the percentage of hemoglobin which is combined with oxygen. In the arterial blood, 95 to 98 per cent of the hemoglobin is combined with oxygen to form oxyhemoglobin which gives its bright color. In venous blood the oxygen saturation is in the range of 70 to 75 per cent. Arterial oxygen saturation below 90 per cent is definitely abnormal.

Oxygen tension is another way of expressing the degree of oxygenation of the arterial blood. If I may digress briefly, I would like to go back to the concept of the partial pressure, because this will come up again when we are talking about CO₂ tension. The room air we breathe has an atmospheric pressure of 760mmHg. We all know that the composition of the room air is 80 per cent nitrogen and 20 per cent oxygen. The partial pressure, therefore, of the oxygen in the room air is 20 per cent of 760mmHg., or approximately 150mmHg. The air in our alveoli is the mixture of the dead space air in our tracheobronchial tree and room air. The alveolar air composition, therefore, has lower oxygen tension and higher carbon dioxide tension. It usually has an oxygen tension of 110mmHg., carbon dioxide tension of 40mm., water vapor tension of 47mm. and nitrogen tension of 560mmHg. with a total of 760mm. The venous blood which comes into the lung by way of pulmonary artery is divided in pulmonary capillaries and thus comes in contact through alveolar wall to alveolar air. The CO₂ in the venous blood diffuses in the opposite direction to the pulmonary alveoli. By the time the blood leaves the pulmonary capillary bed it is equilibrated with the alveolar air and the pulmonary venous oxygen tension is very similar to that of alveolar tension. The pulmonary venous blood eventually becomes arterial blood with little, if any, change in its blood gas tensions. The arterial blood usually has an oxygen tension of 90 to 100mmHg.

and CO₂ tension of 40mmHg. Arterial PO₂ of below 84mmHg. is abnormal.

Hypoxia

Hypoxia can be defined as either reduced oxygen tension in arterial blood or reduced oxygen saturation. The relationship in oxygen tension and oxygen saturation is expressed by the oxyhemoglobin *dissociation curve* and, therefore, definition by either method is satisfactory.

There are several causes of hypoxia: 1) Hypoventilation, 2) Uneven distribution of blood flow in relation to ventilation, 3) Diffusion defect, and 4) Veno-arterial shunting.

The practical example of hypoventilation is overdosage of narcotics or sedation, postoperative situation where muscle relaxant is not completely worn out yet, central nervous system depression of any cause, or splinting of the chest or upper abdomen from surgery or trauma, etc. Hypoxia due to hypoventilation can be corrected by increasing the amount of oxygen in the inspired air, but this is not necessarily the desired method of treatment, as I will mention later, under the CO₂ tension. The example of the uneven ventilation in relation to blood flow is chronic obstructive emphysema where the destruction of the alveolar septa and bronchospasm will affect the different portions of the lung to a different extent. An area, which is rich in blood flow, may be poor in its ventilation. Again, in this condition, the hypoxia is correctable by the administration of high concentration of oxygen. The examples of diffusion defect are the conditions which result in thickening of alveolar capillary membrane. Typical of this is pulmonary edema, pulmonary fibrosis or pneumonitis. This is easy to visualize because gases have to travel farther across the thick membranes. Since the speed of diffusion is proportional to the difference in the partial pressure, by raising the oxygen tension in the alveoli with oxygen breathing, the diffusion defect can be overcome and arterial hypoxia can be corrected. Briefly then, in the first three conditions, hypoventilation, uneven ventilation to perfusion ratio and diffusion defect, hypoxia can be eliminated by administration of oxygen. This is of important diagnostic value and this does not necessarily mean that administration of the oxygen is the treatment of choice. The fourth condition, veno-arterial shunt, is present when there is a right to left intracardiac shunt such as in Tetralogy of Fallot, or right to left extracardiac shunt such as in pulmonary arteriovenous fistula. It is also present in the patient with a severe pulmonary hypertension from various causes, particularly from massive pulmonary embolism. In these situations, the venous blood enters the arterial side and

no matter how much oxygen you administer to the patient, the hypoxia cannot be corrected.

Elimination of Carbon Dioxide

Since there is no appreciable amount of carbon dioxide in the inspired air, the carbon dioxide in the blood originates from the tissue. As the end product of combustion of metabolites, carbon dioxide is produced in the tissue. This is carried by the venous blood to the lung. There the carbon dioxide diffuses from the venous blood across the alveolar capillary membrane into the alveolar space. Since the alveolar space is the mixture of dead space air and room air, its carbon dioxide tension will be determined by the proportion of this mix. At normal breathing, the carbon dioxide tension, or PCO_2 , of alveolar air, is maintained at approximately 40mmHg. After the venous blood is exposed to the alveolar air and passes on to the pulmonary vein, the pulmonary venous blood, which is an arterial blood, will have the same PCO_2 as the alveolar air, namely 40mmHg. with the normal range varying from 35mm. to 45mm.

Causes of increased arterial PCO_2 , or CO_2 retention:

- 1) Obviously, if the patient is given a gas mixture which contains CO_2 , alveolar PCO_2 will increase. This will result in the increased arterial PCO_2 .

- 2) Since the alveolar air is in a state of equilibrium, which is determined by the ratio of mixture between dead space air and room air, the smaller the proportion of the inspired room air, the higher the concentration of carbon dioxide in the alveolar air is going to be. In other words, if the alveoli are hypoventilated the CO_2 tension will increase proportionately to the degree of hypoventilation. The arterial blood reflects this increase in the alveolar PCO_2 very accurately.

The opposite is true also if the patient hyperventilates, either voluntarily or by mechanical assistance. The greater the amount of room air is added to alveolar space, the lower the alveolar PCO_2 becomes. The arterial PCO_2 , likewise, decreases.

Stated briefly, the increase in the arterial PCO_2 indicates that hypoventilation exists, and conversely low PCO_2 indicates that the patient is hyperventilating. The clinical application of this is that if the patient has high PCO_2 , the ventilation has to be increased and this may be achieved by one of the several means according to the underlying condition for the hypoventilation. For instance, if there is an airway obstruction, this has to be removed either by insertion of an airway or aspiration of the tracheal secretion. If this is not sufficient, endotra-

cheal tube or tracheostomy may be required. If the hypoventilation is due to the pain of the chest wall or instability of the rib cage, intercostal block or some means of stabilizing the rib cage is required. If the hypoventilation is due to muscular weakness, whether from narcotic over-dosage or use of muscle relaxant, respiration has to be maintained by artificial means usually by intermittent positive pressure breathing.

Hyperventilation as manifested by low arterial PCO_2 usually does not result in a great deal of difficulty, but if it is desired that this be corrected, the ventilation can be reduced by either sedation or by reduction of the setting of the pressure or flow of the intermittent positive pressure breathing apparatus.

Usually, hypoventilation is the more serious of the abnormalities. Respiratory acidosis can result in increase in the airway resistance and/or depression of the central nervous system to further impair ventilation and establish a vicious cycle. In addition, the respiratory acidosis, if added on top of metabolic acidosis, will aggravate the reduction of the cardiac output. On the other hand, the respiratory alkalosis, or hyperventilation, is relatively devoid of deleterious effect except, perhaps, the cerebral vasoconstriction and production of compensatory metabolic acidosis.

Metabolic Acidosis

Metabolic acidosis results from several mechanisms:

- 1) Hypoxic metabolic acidosis: If tissue oxygenation is inadequate, as a result of reduced blood flow, and particularly in combination with arterial blood hypo-oxygenation, the metabolic products are not oxygenated to its end stage of CO_2 and water. The intermediate products such as lactic, pyruvic acids and other fixed acids accumulate and result in metabolic acidosis.

- 2) Diabetic acidosis is produced by accumulation of p-hydroxybutilic acid, acetoacetic acid and other Ketone bodies due to oxydation of fat in place of sugars.

- 3) It can be produced also by addition of fixed acids to the blood stream. Here, we shall be concerned mainly with hypoxic metabolic acidosis.

Metabolic acidosis during operation, or after operation, indicates that tissue hypoxia exists or has existed. This is usually the result of reduced cardiac output with or without inadequate blood oxygenation. Metabolic acidosis has deleterious effects on cardiac output and other cellular function, and tends to be self-perpetuating. It is mandatory that the acidosis be corrected by appropriate means, and

further development of acidosis prevented by removal of cause, be it low cardiac output or arterial hypoxia. Chemically, metabolic acidosis is not as readily measured as respiratory acidosis.

Human blood has a buffer system which comprises of carbonic acid-bicarbonate. The acidity of blood, or pH is influenced in this buffer system by two variables, namely, carbonic acid concentration, and bicarbonate ion concentration. The carbonic acid concentration in blood is strictly proportional to CO_2 tension. That is, if PCO_2 doubles, the carbonic acid concentration doubles. In other words, carbonic acid concentration can be expressed in terms of arterial PCO_2 .

The bicarbonate component has slightly more complex variations. As fixed acid accumulates in the body, bicarbonate combines with this and becomes depleted. Thus, metabolic acidosis is manifested by lower serum bicarbonate. Unfortunately, bicarbonate varies not only with the metabolic state, but also with the state of ventilation.

Let us take an arterial blood sample from a normal patient. It has PCO_2 of 40mmHg. and bicarbonate of 24mEq. There is neither respiratory acidosis or metabolic acidosis. When this sample is exposed to air, CO_2 is allowed to escape, PCO_2 decreases and respiratory alkalosis develops. There has not been any metabolic change. Yet, when one analyzes this sample for bicarbonate, one will find that bicarbonate value has decreased. Conversely, when PCO_2 is increased in the blood sample by bubbling CO_2 through it, bicarbonate concentration increases without metabolic changes taking place. Obviously, bicarbonate value cannot be taken to indicate the presence or absence of metabolic acidosis or alkalosis.

Measuring Metabolic Acidosis

Yet, there is a need for some yardstick to measure metabolic acidosis. The concept of standard bicarbonate is originated for this purpose. Since two factors affect bicarbonate values, namely, PCO_2 or respiratory state, and metabolic state, if one can hold respiratory state at a standard condition, that is PCO_2 of 40mmHg., then whatever deviation bicarbonate may show will be strictly due to metabolic state. Thus, one can define "standard bicarbonate" as the value of bicarbonate determined at 40mmHg. or calculated to be, and this will be an accurate measure for metabolic state.

Thus, we have a good indicator of metabolic state in "standard bicarbonate." The term, "base excess" simply expresses the value of the bicarbonate in excess of normal standard bicarbonate

value. For instance, base excess of +6mEq. means the excess of 6mEq. of standard bicarbonate, i.e. metabolic alkalosis, and negative values indicates metabolic acidosis.

pH is the sum total of respiratory factor and metabolic factor and can be expressed mathematically as $\text{pH} = \text{pK} + \log \frac{(\text{HCO}_3^-)}{(\text{CO}_2)}$, pK being dissociation constant for bicarbonate and is 6.1. The equation can be rewritten as $\text{pH} = 6.1 + \frac{(\text{HCO}_3^-)}{(\text{CO}_2)}$. Normally, HCO_3^- is 24mEq., PCO_2 40mmHg. equals H_2CO_3 concentration of 1.2mEq. Ratio of $\frac{(\text{HCO}_3^-)}{(\text{CO}_2)}$ therefore is 20. $\log 20 = 1.3$ $\text{pH} = 6.1 + 1.3 = 7.40$ and we have our normal pH. When CO_2 is retained, respiratory acidosis exists. (CO_2) increases, and pH decreases. When metabolic acidosis is present, HCO_3^- is depleted, and pH decreases. It is clear that pH value is influenced by respiratory and metabolic states. By just looking at pH one knows if there is acidosis, but one may not know which type. One should look one step further into PCO_2 and standard bicarbonate to really know what acid anomaly is present. Let us look at the Astrup chart. One needs to look at only a few items to come up with his assessment of the situation. These are: 1) oxygen saturation, 2) pH, 3) actual PCO_2 and 4) standard bicarbonate or Base Excess.

Correction of Acidosis

Two types of acidosis must be distinguished since treatment is entirely different.

1) Respiratory acidosis: If acidosis is due to respiratory factor, that is CO_2 retention as manifested by high PCO_2 , this means hypoventilation is present. Treatment, as mentioned before, is improvement of ventilation, whatever it takes. Clearance of airway, relief of rib cage pain, intubation or assisted ventilation. No bicarbonate or THAM is needed.

2) Metabolic acidosis: Negative value of Base Excess, or low value of standard bicarbonate indicates presence of metabolic acidosis.

Since bicarbonate is distributed in extracellular space the total deficit is not difficult to calculate.

If Base Excess is -9mEq/L, given a 70 Kgm man $9\text{mEq/L} \times 70\text{Kgm} \times 0.3 = 189\text{mEq}$. Simply stated, 70 Kgm man has 21 L of extracellular fluid and each liter has 9mEq. deficit of bicarbonate. The calculated total deficit can be given in form of NaHCO_3 intravenously in five to 10 minutes. This usually corrects metabolic acidosis. The causes which resulted in metabolic acidosis, such as low cardiac output, must also be corrected if one is to prevent further accumulation of metabolic acids.

Memorial Hospital of Chatham County

Placenta Biloba in Uterus Arcuatus

WITH SPECIAL INVESTIGATION OF THE FETAL MEMBRANES

RICHARD TORPIN, M.D., and FRANK C. STORY, M.D., *Augusta*

VARIATIONS IN THE SHAPE of the uterus are well investigated by distending an expelled fetal sac with water while it is suspended in a tank of water.¹ Thus the sac assumes the exact shape and size of the uterine cavity at the time of termination of pregnancy. The normal uterus at term produces a fetal sac pear shaped (holding 3 or 4 thousand cc) with lateral fundal bulges to denote the horn areas. From observation of these lateral protuberances the orientation of the sac in the uterine cavity may be recognized but seldom can one determine the posterior portion from the anterior.

The distinctive characteristic of primate placentation is due in part to the shape of the uterine cavity. This differs markedly from many lower animals whose uterus is composed of two long tubes with circular canals. In the primates, the potential uterine cavity is triangular in shape and lies between two triangular sheets of deciduae: ventral and dorsal. These are joined at the lateral regions and at the top of the fundus to form a continuous crease or sulcus up one side, over the top and down the other side. If the fertilized egg implants into this sulcus the result is almost invariably production of a placenta biloba (bipartita). If the egg implants near to but not into the sulcus the placenta is usually discord but on rare occasions placenta succenturiata may occur with the small extra placental disk on the opposite ventral or dorsal wall.

Chester Martin,² who has had experience at the Carnegie Institution of Embryology, informed us that he has observed several instances of placental bilobation in the rhesus monkey (*Mucaca mulatta*). In these the joining of the usual two disks occurred over the top of the uterus and none were over the sides.

Presence of Bilobation

In a previous investigation³ among 4098 fresh placentas, bilobation was present in 355 cases (327 at term and 28 abortion or premature deliveries). Twelve hundred of the fetal sacs were studied by

distension of the sac while it was suspended in a tank of water. Scale clay models of each of the 1200 recorded the exact extent and site of the placenta. Eight and six-tenths per cent showed some form of bilobation. The incidence was similar in Caucasian and in Negro women. The two lobes lay one on each side of the apical sulcus as often as over the two lateral sulci combined. Usually one lobe is much smaller than the other but in approximately one-third of the cases the lobes are equal or nearly equal in area and weight.

From previous observation of distended fetal sacs by one of us (RT) it has been noted that this arcuate type of uterus in some gestations may be associated with transverse lie of the fetus. This is one of the values of the fetal sac distension method of study. One may recognize various shapes of the uterine cavity all the way from single horn with a fusiform sac to extreme arcuation with a partial septum.

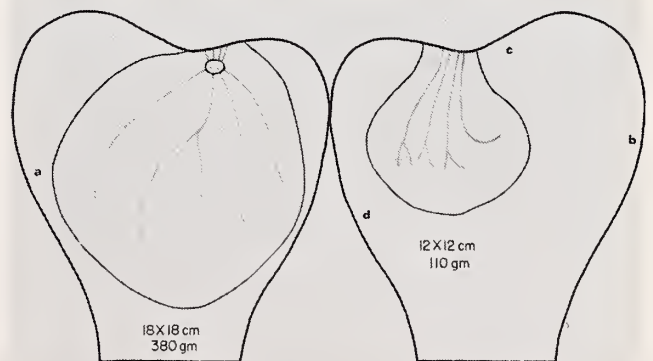


Figure 1. Hypothetical model of the distended fetal sac, bisected laterally with the dorsal and ventral halves laid open. This reveals the inside view with the two placental lobes joined at the top of the uterus; the dimensions in cm and the weights in gm. The fetal blood vessels are drawn to scale. The umbilical cord was 50 cm long, with practically no twisting, and had two arteries and one vein. It was inserted into the larger lobe at its upper margin near the sulcus dividing the two lobes. The capacity of the sac was 3200 cc with the newborn infant weighing 3010 gm.

PLACENTA BILOBA / Torpin, Story

In this case the mother, married 18 months, was Caucasian, 21 years old, gravida 1, para 0. She weighed from 110 to 134½ pounds and the hemoglobin ranged from 11.9 to 13.2 grams in the pregnancy. The blood pressure and urine tests were normal at all times. She was blood type A, Rh positive and her personal and family clinical histories were essentially negative. Her parents, three brothers and six sisters were living and well. At term her labor was five hours and twenty-eight minutes in duration. A normal female infant (Apgar score 8) weighing 3010 gm was born spontaneously from occiput left anterior presentation and position. She was a patient of Frank Story, M.D., who recognized the anomalous placenta and saved it for study. The delivery took place at St. Joseph's Hospital, Augusta, Georgia.

Gross sections of the fetal membranes from this sac were taken at areas A, B, C, and D in figure 1. These were grossly stained by hematoxylin and eosin and viewed by a dissecting microscope with reflected light at 6.6 x and at 30 x. Thus were seen the chorionic villi remnants (villi ghosts) in their entirety at the various sites in the fetal membranes. Most of them were bush-like and pressed flat. No colloid villi were noted in this sac. Near the edge of the placenta these villi tend to lie with their heads away from the placental margin. A hypothetical reason for this phenomenon has been pre-

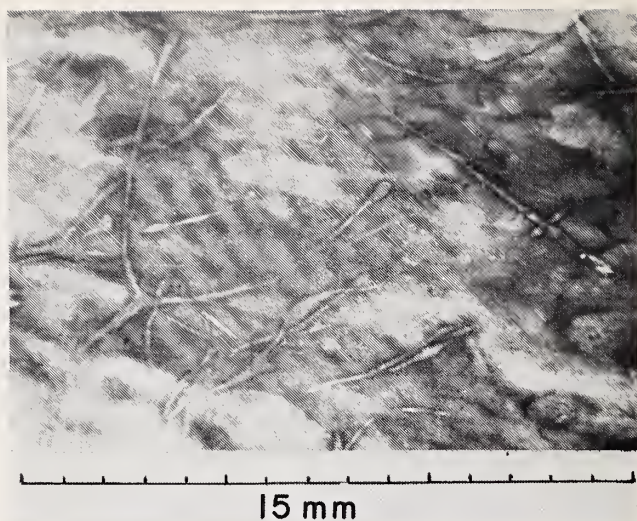


Figure 2. Photomicrograph (6x) of a gross sheet of fetal membranes from site figure 1-b, and shown with measuring scale and revealing the atrophic chorionic villi remnants in the decidua capsularis layer. Some villi may appear in coils but none were discovered in this sac's membranes.

sented elsewhere.⁴ Some villi may be 3 or 4 cm long.

Medical College of Georgia

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FIRST NEW STATE HEALTH DISTRICTS ACTIVATED

The first five of Georgia's new public health districts have been approved and became operable July 1, according to information released in Atlanta by state health director Dr. John H. Venable.

Redistricting is underway statewide to improve provision of local health care through reduction in the number of districts, and the better utilization of health resources. The plan recommends reducing the present 38 districts to an anticipated 13 or 14.

Dr. Venable explained that a final local decision has not yet been reached on whether the nine-county metropolitan Atlanta area will be served by one or two health districts. This eventual decision, he said, will set the final total of multi-county districts in the state at either 13 or 14.

The health official has said that the new district plan—which is the result of several years of professional and citizen study—will, “get the most services to the most people for the tax dollar spent and the human energy and skills used.”

The new districts, identified by location and tentative numerical designation are shown below. In each

case the headquarters county—based on local decision—is shown first:

—East Central (VII): *Richmond*, Columbia, Burke, Screven, Jenkins, Emanuel, Jefferson, Glascock, Warren, McDuffie;

—West Central (VIII): *Muscogee*, Harris, Taylor, Talbot, Dooly, Sumter, Webster, Quitman, Stewart, Chattahoochee, Marion, Schley;

—South Central (IX): *Laurens*, Johnson, Treutlen, Montgomery, Toombs, Wheeler, Jeff Davis, Telfair, Ben Hill, Wilcox, Dodge, Bleckley;

—East (X): *Chatham*, Bryan, Liberty, Tattnall, Evans, Candler, Bulloch, Effingham;

—Southeast (XIII): *Ware*, *Glynn* is a sub-headquarters county, Camden, Long, McIntosh, Wayne, Brantley, Charlton, Clinch, Atkinson, Coffee, Bacon, Appling, Pierce.

As approved by the Georgia State Board of Health, the new redistricting plan allows until June 30, 1973 for total activation of districts to include all of the state's 159 counties. The date of activation is determined by the local involved counties.

Who Picks Up the Ugly Baby?

GEORGE R. SWERDLOFF, D.D.S.,* *Atlanta*

IN ANY NURSERY or orphanage the pretty, sweet-smelling child is picked up, held, spoken to or otherwise receives attention. The ugly child perhaps not so sweet-smelling, does not receive the same attention, and thus begins his feeling of rejection and alienation. Does medicine pick up the baby called Byron? Having been in some measure responsible for the medical effort at the "pop festival" at Byron, I have been asked to record both my impressions and what data we could gather. What I have to say is controversial and solid reasons can be given both pro-and-con organized medicine's involvement in a questionable enterprise.

Regardless of one's moral or philosophical convictions, only physicians can provide medical care. If organized medicine ignores or leaves to "other groups" the provision of health care, then both people and our image suffer. If we had not gone into the medical vacuum at Byron, there would have been no medical care. And with no on-site medical care, some people would have died.

Strong community efforts were made not to allow the festival to happen. Medical support was not the deciding factor, nor even an important factor in the go-or-no-go situation.

Planned Medical Support

I was asked by several members of Fulton County Medical Society to plan medical support for the festival, and with the Board of Trustees' approval, attempted to carry out this mission. After meeting with the promoters, it became apparent that financial support for staff would not be forthcoming. There were statements made that volunteers called them everyday and that there was no need to compensate physicians, nurses, and paramedical personnel. However, they did agree to pay for medical supplies, to provide a direct line to the Macon Hospital, an internal communication system, tables, chairs, cots, tentage, ambulances, helicopter, food and motel rooms.

They (the promoters) also stated that there would be O.D. tents and O.D. personnel adjacent to each medical tent. O.D. refers to "overdose" and the personnel were supposed to be skilled in restraining and talking down "bad trips." One of our medical stipulations was that *all* drug overdoses were to be seen by a physician prior to "talk down."

A meeting was held with representatives of Bibb County Medical Society and Macon Hospital. They were assured that we would evacuate to them only "true medical emergencies" which we could not handle in the field.

Planning for Medical Personnel

We visited the festival site and designated areas where we wanted our medical tents established. The promoters estimated the size of the crowd would be between 50 and 750,000.* With this background information, we decided we would need six physicians from noon to midnight, and three physicians from midnight to noon. It was also determined that each physician could use two nurse assistants.

From the Atlanta area we were able to recruit 22 physicians, approximately 30 nurses, and 10 medical students. The Atlanta physicians came as representatives of such groups as the Fulton County Medical Society, Christian Medical Society, Medical Committee for Human Rights, the Communicable Disease Center, Emory and Grady Hospital. From the Macon area there were about six physicians who served and these were from the Macon Hospital and a Methodist Church in Warner Robins. Two physicians from South Carolina appeared at the festival and volunteered their services. Reasons for physicians' volunteering were varied. Some of the reasons were Christian Duty, curiosity, one's children being there, and a way to acquire data. Some identified with the population and "dug" the group, while others just felt it was the thing to do.

* Administrative Medical Director, Comprehensive Health Care Planning Program, Fulton County Medical Society.

* State Patrol and newspapers subsequently estimated the crowd to be between 200,000 and 400,000.

Four medical tents and three O.D. tents were operational from Thursday afternoon to Monday afternoon. The tents were open on all four sides, privacy was impossible and, as we were overwhelmed with patients coming at us from all sides, record keeping was next to impossible.

Communication and Transportation

We did not have a direct line to the Macon Hospital and communication between the various aid stations was by means of sometimes-operational walkie-talkies. There were two commercial ambulances present most of the time, and these were used mainly to evacuate patients to the Macon and Houston Hospitals.

Private vehicles (station wagons and trucks) were pressed into service, marked with red crosses and used for transporting patients, supplies and medical personnel between aid stations. Surface roads, internal and external, were jammed with people and cars, and it was most difficult to evacuate patients. The commercial helicopter had no mechanism for carrying litter cases and only one patient was evacuated by this craft. From midnight Saturday to midnight Sunday we had the use of an Army helicopter. This was used about six or seven times in evacuating patients to Macon. As an interesting sidelight, the commercial ambulance drivers complained that they were being stopped on the highway and given tickets by the Sheriff's Department for speeding and using sirens.

Medical supplies were purchased in Atlanta and brought to the festival in a borrowed camper. This was our "supply base" and medicines and supplies were distributed to the various medical tents. The camper remained at the so-called "Main Medical Tent" and was used as a pharmacy. I underestimated the amount of salt tablets and first aid supplies needed, as well as the amount of sedatives needed for drug overdoses. During the course of the festival, we replenished our supplies by purchase from a Byron pharmacy, Macon Hospital, and Central State Hospital at Milledgeville.

During the first official festival day, Friday, the temperature reached 104° and there were about 75 heat exhaustion cases. Based on this, the State made available to us from one of its standby disaster hospitals, cots which the promoters had not supplied in an adequate amount, and I.V. fluids. Fortunately, the weather was a little cooler on Saturday and Sunday. The cots were used, the I.V. fluids were not, and all the material was returned to the State Monday afternoon. That is, all except approximately 10 cots which were stolen.

Inadequate Facilities

Water and sanitary facilities were inadequate. On advice of the State Health Department, we turned the showers off on Sunday to conserve water. With the mountains of soft drinks available, we would never have run out of liquids. The number of salt tablets would have been adequate for 100,000, but not the 250,000 present. The pumper that was supposed to keep the port-o-lets empty claimed he could not get to them because of the crowd, and when he did empty a series he had to travel quite a distance to empty his pumper. Some of the port-o-lets were not cleaned during the entire festival period.

The three area hospitals reported a total of 143 emergency room visits, which they ascribed to the festival. This report is from the period starting on Tuesday, June 30 through Monday, July 6.

Name*	E.R. Visits	Hospital Admissions
Peach County Hospital	25	0
Macon Hospital	63	15
Houston County Hospital	55	5
Total	143	20

* Source—Individual Hospital Administrators

Hospital Admissions

The 20 hospital admissions diagnoses were fracture, pancreatitis, post cardiac arrest, childbirth, infectious hepatitis, stab wound, head injury, LSD overdose, emphysema, burns, and fever with abdominal pain.

Of the total number of hospital visits, about 25 per cent came through the festival evacuation chain and the others found their own way without seeking help at the festival aid stations. Of the hospital admissions, almost all were seen and evacuated by physicians working at the festival.

Considering all the hazards inherent in the bringing together of all the young people, normal and not so normal, in a confined area, it is a medical miracle and a tribute to the efforts of the physicians present that there were no fatalities and so few hospital admissions.

Another moral problem presents itself in the question of hospital reimbursement. On the one hand, it can be said that the promoter arranged for the ingathering of people and overloading of the community's health facilities. Therefore, he (the promoter) should be responsible for the patients' hospital costs. On the other hand, many of the people serviced were from middle-and-upper-income

families and medical costs should be assessed against them or their families.

Treatment of Patients

We estimate that 6,000+ patients were seen in the medical tents at the festival site. Of these, approximately half were drug overdoses. The great majority of drugs used were hallucinogens and stimulants. Very few narcotic addicts presented themselves at the medical tents. Those addicts who did appear came late Sunday night and early Monday morning. They evidently had run out of either supply or supplier and needed something to get them off of withdrawal pains and started home. Some of the drugs admitted to bore such names as acid, yellow sunshine, mescaline, speed, purple microdot, orange sunshine, STP, blue microdot, LSD crystal and psilocybin. Marijuana was used as commonly as cigarettes and alcohol at a cocktail party. To the best of my knowledge, we saw no marijuana overdose.

For some of the physicians present, it was their first experience in seeing and treating drug overdoses. In this respect, the festival can be called an educational experience.

The majority of the non-drug cases seen were lacerations, abrasions, sprains, sunburn, blistered feet, heat exhaustion, burns from motorcycle ex-

haust, heat fatigue, and G.I. upset. Minor suturing was done in the medical tents.

False Rumors

I do not, nor to the best of my knowledge do any of the physicians involved, condone drug usage, nudity or obscenity. In spite of the rumors and fables which will accrue with time, probably 95 per cent of the people present *did not* use drugs, and probably 99 per cent of those present *were not* nude or obscene. It is amazing that in a crowd of this magnitude there is only one documented case of violence—the stabbing. One fool shot himself in the hand, was evacuated and returned to the festival. A great percentage of the young people present were there for music and/or togetherness. In spite of their long hair, many of the youths were not so-called “hippies” but came from middle class America. A festival is not unlike a convention—at the festival, wrongdoing was open: at a convention, it is more surreptitious. Perhaps this is what our children are trying to tell us.

It is to the credit of physicians that they did give of their time, talent and energy. If I listed all the volunteer physicians, physicians' wives, nurses and paramedical people, I would probably inadvertently omit one. Therefore I shall not list any. They know who they were and I thank them for making my task easier. God Bless Them.

875 West Peachtree Street, N.E.

THE DEVIL'S DICTIONARY

ABSTAINER, n.—A weak person who yields to the temptation of denying himself a pleasure. A total abstainer is one who abstains from everything but abstention, and especially from inactivity in the affairs of others.

—Ambrose Bierce

AID IN ESTABLISHING PRACTICE

The vital but too often overlooked business side of the practice of medicine is examined in a new periodical published by Bank of America.

Entitled “Establishing a Medical Practice,” the report offers practical advice on a number of subjects for the young doctor.

“Many young physicians completing their internships and residencies and beginning their practices are familiar with today's medical atmosphere but have little or no knowledge of the economic aspects involved in the private practice of medicine,” the report states.

“In addition to selecting the type of practice, a young doctor must choose a location; select an office and home; secure licenses; establish rapport with the

local medical society, colleagues, community hospitals; and in general discover there is a business side of the practice of medicine.”

The report covers choosing an office location, equipment needs and approximate prices, financing, insurance, employees, records, billing, and fees and collections.

To help the doctor in selecting his location, the report includes a chart comparing each state's share of active M.D.'s with its share of the nation's population. It also includes a county by county breakdown of the California physician population ratio.

A single copy of the report may be obtained free by writing Professional Management, Dept. 3120, Bank of America Center, San Francisco, California 94120.

Services Available Through MAG

J. RHODES HAVERTY, M.D., *Atlanta*

TODAY'S COUNTY MEDICAL SOCIETY is not only a scientific and professional organization, but also much more than that. It is a community leader. It is looked to by the public for guidance in all health matters. Medicine, with its long tradition of continuous learning and education, never stands still. That is why the county medical society today is eminently qualified to fill the role of community leader in many fields. In its position as a community leader, the medical society assumes heavy public responsibilities. Active society programs are essential and public service must be their key.

You will be interested in some of the many services available through the Medical Association of Georgia headquarters office and staff. Through the headquarters office an Executive Director and his staff administer the business of the Association and assist members and their organizations. A complete biographical file is maintained on each member and this confidential information is available, if authorized. The headquarters office assists in physician placement by serving as an aid to doctors seeking a location, and to communities needing a physician.

The field representative on our staff maintains liaison with the county medical societies and upon request lends assistance.

The headquarters office can furnish a physician to discuss scientific or non-scientific subjects at your county society meeting upon request and also on request the Association renders assistance to specialty societies in scientific and organizational matters. Secretarial and bookkeeping services for various medical groups are available by contract with MAG.

Efforts are being made to keep county societies informed concerning MAG policies and activities. The MAG will at all times render advice and assistance to county societies on any problems they may have. MAG with its state-wide experience and efficient office staff stands ready to serve you.

The *Journal of the Medical Association of*

Georgia publishes scientific articles, want-ads, advertising of current drugs, current events and activities of MAG. In addition, a membership yearbook is published each year listing MAG Officers and Committees, District Society Officers, Specialty Society Officers, County Society Officers, Hospitals in Georgia, Alphabetical Roster of Members, Component Society Roster of Members, and the MAG Constitution and Bylaws.

A list of new members, reinstated members, change in status and deceased members and the total from one month to the next in membership is provided in a monthly membership report.

A monthly report is mailed to County Medical Society Presidents and Secretaries, Executive Secretaries, Council and Executive Committee members, listing meetings and other events scheduled both nationally and in Georgia.

Staff Services

The staff prepares committee meetings, agendas and calls and sets up physical arrangements. They take minutes and carry out directives of the various committees. The staff handles all routine correspondence and requests from the public, Georgia physicians, out-of-state physicians, and the press, reviews all literature from other states and the AMA, and utilizes all information which can benefit MAG.

Each year the MAG sponsors a meeting of all the MAG Committees. At this meeting all MAG Committees have an opportunity to meet and conduct their regular course of business.

On April 17, 1967, the Medical Association of Georgia Foundation, Inc., was chartered by the Superior Court of Fulton County, Georgia. The Foundation is authorized to engage in and carry out scientific research, charitable, educational and scientific activities and projects both in its own name and as agent, trustee, or representative of others and to make contributions to other charities, contributions to which are tax deductible.

The Foundation also specifically is authorized to lend financial assistance to needy members of the

medical profession and their families; to assist medical students and paramedical students in the pursuit of their education; to administer governmental programs and grants; and to accept and hold as assets of the corporation in trust or otherwise consistent with its other charitable purposes.

Aid to Military Dependents

Prior to 1956, medical treatment for families of servicemen was provided for only in uniformed services medical facilities, and then only if space and staff were available. Families not residing near such facilities were sometimes hardpressed to get needed or adequate care, because the average income of servicemen was low. The Dependents' Medical Care Act of 1956 helped to fill this void by providing payment to *Civilian* sources rendering care to the wives and children of active duty servicemen.

The MAG chose to be involved in the program and to have a hand in its operation, rather than to leave administration entirely up to the government. The MAG applied for and was chosen as fiscal agent and administrator of CHAMPUS, and presently is one of only three State Medical Associations in the United States so operating.

The Medical Association also elected to play a vital part in the planning and direction of the Georgia Regional Medical Program when enabling legislation was signed in 1965. The forward thinking physicians of MAG were responsible for our region's being one of the first Regional Programs to become active. It has been in operation since July, 1968. Through the Georgia Regional Medical Program, Georgia physicians and other health personnel are better able to serve the needs of the people of our state by being better informed, and by having more up-to-date facilities and knowledge related to patient care.

Strength Through Committees

When it comes to evaluating the strength of a voluntary organization, a good place to begin would be to look at the committees, their make-up, purposes, and most of all their accomplishments. This is one area where MAG shines. Those of you who serve on committees of MAG know of what I speak. Our Conclave of Committees which meets each summer looks like a small House of Delegates in session. These two-day sessions, when every committee of the Association meets, bring some 250 of you together.

Let me tell you a few of the activities included in some of the committees, as representative of how the State Association helps the county societies and the individual members throughout Georgia.

A biennial Conference on Medical Education is

sponsored by the MAG Medical Education Committee. Physicians are recognizing more and more the need for Continuing Medical Education and proper training and utilization of Allied Health personnel in this era of rapidly expanding knowledge. The MAG must take the lead in developing and directing training for physicians which is practical, challenging, and fills the needs in all areas of practice. I believe the MAG would prefer to take the lead in this field rather than having others, including the government, dictate the type training a physician should have. The committee constantly is studying a more effective way to conduct Continuing Medical Education for Georgia physicians. Assistance is given to physicians and to the public in promoting recruitment of Allied Health personnel to fill the ever increasing need for Allied Health workers. This committee assists also by maintaining and distributing films, recruiting material, offering program assistance, etc.

Effective Committee

Such tangible returns as money saved on our group insurance premiums do not just happen by themselves. This particular occurrence is the direct result of some careful planning and deft bargaining through annual negotiating meetings with the representatives of underwriting companies by our Insurance Committee. This committee, headed by Bill Moore, will be meeting later this month to negotiate with representatives of the St. Paul Company on our premium rates for the next 12 months of coverage under our group malpractice liability plan. This plan alone brings a member savings of several times his annual dues since, through careful management, our group experience commands a rate over 50 per cent less than established bureau rates for the state. The Insurance Committee has other important duties too, and serves as our liaison on insurance matters with such bodies as the Workmen's Compensation Board and the State Insurance Commissioner's office.

Of course, if you think that is a big job, let me tell you briefly about the Committee on Medical Review and Negotiating. Years ago when the health insurance carriers were initiating the first major medical plans and beginning to receive the first statements from physicians on a usual and customary basis, they were inexperienced in handling any claim that did not fit their old fee schedules. The carriers came to the MAG and the Fulton County Medical Society and asked for help. The Fulton County Medical Society agreed to form an Insurance Review Committee and to serve as the pilot for this revolutionary new concept. Fulton's experience led to the writing of the Review Guide-

lines and the creation of the MAG Committee on Medical Review and Negotiating, charged with the establishment of District and Local Review Committees. In addition, the State committee serves as an appeal board of Local and District recommendations. Council, at its meeting next month, is expected to expand the limits of authority of the Committee on Medical Review and Negotiating so that they will be able to negotiate in MAG's behalf with Medicaid and other carriers for the privilege of being the contractual agency to conduct peer review of all their claims. That is a big job, but through a strong and active committee a great deal of important work can be done.

Ad Hoc Committee

In the past, some important items of specific business have been assigned to Ad Hoc Committees and this has proven to be a valuable approach. With the number of members who have affiliated with the MAG, the variety of talent available is truly endless. Who would have thought that right on the Executive Committee of MAG would be found an Architectural Engineer who would be able to lend a truly expert hand to the work of the Ad Hoc Committee on Building Expansion. I am speaking, of course, of Tex Eldridge, and the results of that committee's hard work can be viewed by any of you tomorrow afternoon following adjournment of these sessions. It is your building and each of you should know it and enjoy it. After all, each of you has a \$100 stake in being able to relay to your county membership that their contributions are justified. Additional Ad Hoc Committees such as the Committee to study the use of Externs in Hospital Emergency Rooms will continue to be formed and used to advantage by the Association. The Ad Hoc Committee on Special Finance has been discharged after submitting its findings and recommendations. It was partially this committee's farsightedness that spurred us to begin and complete the fine structure which not only houses the MAG Staff, but also stands as a symbol of the strength and position of influence which the MAG commands. Incidentally, I have just finished rereading the Himler report of the Clinical Session 1969 of the AMA. One of the sections of this document deals with influence of the medical profession in controlling its own destiny, of which not the least portion of this influence involves visible talismans of prestige which the profession can exhibit to the public in a community—and of which the new Headquarters Office is a beautiful example.

I have mentioned mainly committees of a socioeconomic nature while there are also the scientifically oriented committees as well, and they are all hard workers too. I know that some of you have heard the gag line that a camel is a horse that was put together by a committee; well, let me tell you that the MAG is put together by committees and it carries the burden of the collective voice of the profession quite adequately. There are 30 such committees at work for us right now, and your participation is invited, encouraged and urged.

I would like to conclude with an ending of my own presentation as well as a prelude to Dr. Walker's. It is one other example of the vision and wisdom of one of the giants of our profession.

"It should be a source of special pride to American physicians to feel that the national association of this country—the American Medical Association—has become one of the largest and most influential bodies of its kind in the world. We cannot be too grateful to men who have controlled its course during the past 10 years. The reorganization so efficiently carried out has necessitated a readjustment of the machinery of the state societies, and it is satisfactory to know that this meeting of our state society, the first held under the new conditions, has proved so satisfactory. But in the whole scheme of readjustment nothing commands our sympathy and co-operation more than the making of the county societies the materials out of which the state and national associations are built. It is not easy at first to work out such a scheme in full detail, and I would ask of the members of this body not only their co-operation, but an expectant consideration, if the plan at first does not work as smoothly as could be desired. On the county members I would urge the support of a plan conceived on broad national lines—on you its success depends, and to you its benefits will chiefly come.

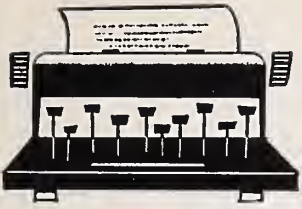
"Linked together by the strong bonds of interests, the profession of medicine forms a remarkable world-unit in the progressive evolution of which there is a fuller hope for humanity than in any other direction."

These words were taken from an address given to the Medical and Chirurgical Faculty of the State of Maryland, 1905, by Sir William Osler, entitled *Unity, Peace, and Concord*.

What can MAG's committees and staff do for you as an officer of your county society?

About anything you need, Doctor.

33 Gilmer St., S.E.



Rural Health Conference Scheduled for September

THE SIXTH ANNUAL RURAL HEALTH CONFERENCE is scheduled for Wednesday and Thursday, September 9-10, at the Alpine Motor Lodge in Macon, Georgia. Jointly sponsored by the Medical Association of Georgia Committee on Rural Health and the Georgia Farm Bureau Federation, the 1970 version is designed to inform registrants of some of the current problems facing rural Georgia and how many of the problems may be solved.

The keynote speaker will be Mr. Mac Guest, Field Representative of the American Farm Bureau Federation. Mr. Guest has served as County Agent with the Cooperative Extension Service and served 10 years as Director of Field Services for the Georgia Farm Bureau Federation. Mr. Guest will be covering health problems and how many of the health problems have been solved in other states.

Other areas of emphasis include: Home Poisoning and Accident Prevention, Pesticides Use and Abuse, Recreational Safety, Rural Development Center, Drug Abuse, Nutritional Projects and Medical and Allied Health Recruiting.

The 1970 Program was drafted by the Georgia Rural Health Council, which is composed of representatives from the Georgia Congress of Parents and Teachers, Georgia Vocational Education, Georgia Safety Council, Georgia Department of Public Health, Georgia Farm Bureau Federation, Georgia Extension Department, State Department of Education, and the Medical Association of Georgia.

The two-day Conference will draw approximately 125 persons from all areas of Georgia representing both State and Local rural organizations.

L-DOPA and Parkinsonism

THE RELEASE OF L-DOPA last month for general medical use in the treatment of parkinsonism was a long anticipated event. The collective efforts of individual research physicians, the private drug industry, and collaborating medical centers deserves special commendation. Three individuals, Professor Oleh Hornykiewicz, Dr. Andre Barbeau, and Dr. George Cotzias deserve separate and special recognition for their early and continuing basic research in the neurochemistry of dopamine metabolism and the subsequent application of L-DOPA in the therapy of Parkinson's Disease and syndrome.

There are, by conservative estimates, 300,000 clinically identifiable cases of parkinsonism in the United States. We know that only 20 per cent of proven cases of parkinsonism have the disorder listed on death certificates at the time of death. One could then safely assume that the disease is underdiagnosed and the true number of clinically affected is greater than the above estimate. The magnitude of the treatment problem and our responsibility is probably greater than we now realize.

Basically, the physician needs to answer two questions: 1) Does the patient

have parkinsonism?, and 2) Should the patient receive L-DOPA? In most situations these questions will be easily dealt with. There will, however, be some clinical situations in which the diagnosis is in doubt, and others in which the drug is not indicated. The successful use of L-DOPA on a large scale by the practicing medical profession is dependent on answering these two questions accurately for each patient. The improper use of L-DOPA could rapidly produce disillusionment on the part of doctors, patients, and the drug industry. It is not the purpose of this editorial to review all of the technical aspects of using L-DOPA. For this the physician using L-DOPA is encouraged to review the recent literature. Let us, however, consider in some detail the two proposed questions.

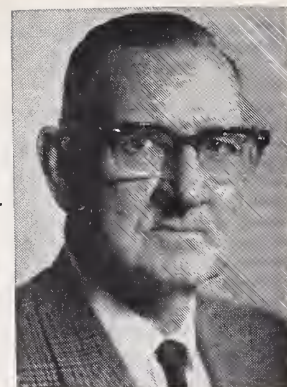
Parkinsonism is a clinical syndrome, the diagnosis of which is based on history, physical findings, and subsequent course. Pathologically there are some consistent findings but these are of little use to the clinician. There are no biochemical or neurophysiological tests available to the clinician that will confirm the diagnosis. Parkinsonism consists of varying degrees of rigidity, tremor, and akinesia. The degree of each will vary from patient to patient and will on occasion vary from right to left side within a single patient. The masked facies, "pill rolling" tremor, cogwheeling, retro and anteropulsion and shuffling gait are all manifestations of these three basic disorders: Rigidity, tremor and akinesia. Blepharospasm, sialorrhea, seborrhea, micrographia, feeble speech, depression and dementia are other common manifestations of the syndrome. In our population, the physician will need to separate true parkinsonism primarily from three other disorders: 1) senility or pre-senility with dementia and "gegenhalten" (plastic resistance to passive motion), 2) the elderly patient with a slow shuffling gait who has senile tremor or an essential tremor, and 3) the patient with bi-pyramidal cerebrovascular disease manifest by pseudobulbar palsy, rigidity, increased reflexes and slow shuffling gait. The use of L-DOPA in these latter groups would be costly and ineffective.

Less commonly observed but also diagnostic considerations are other degenerative neurological syndromes in which parkinsonism is a part of the clinical spectrum. This includes: 1) Cerebellar ataxia with parkinsonism, 2) Creutzfeld-Jacob disease, 3) Parkinsonism and Amytrophic Lateral Sclerosis, and finally 4) Progressive Supranuclear Palsy (Heterogenous System Degeneration). L-DOPA has not yet been demonstrated to be of value in these disorders.

Having accurately diagnosed the case of parkinsonism, the physician now needs to consider whether or not the use of L-DOPA is warranted. Probably no patient is too severely afflicted with parkinsonism not to warrant a cautious therapeutic trial of L-DOPA, a more difficult decision related to the patient with minimal involvement or who is satisfactorily controlled on other medication. There is no current evidence which indicates that L-DOPA alters the natural history of parkinsonism or that a patient's responsiveness to L-DOPA will be lessened by waiting for symptoms and signs to fully develop. Because of the cost, the need for continuous use of high dosage, and the oftentimes aggravating side effects, it seems reasonable to withhold the drug in mildly affected cases, particularly if they are able to maintain a reasonable degree of activity and productivity. When the disease begins to interfere with a person's "life style," then L-DOPA is indicated.

The reader should not be discouraged from using L-DOPA but should be encouraged to begin looking more critically at the accurate diagnosis of degenerative neurologic diseases. Parkinsonism is only the first of many that will eventually have more specific therapy.

*William H. Stuart, M.D.
Atlanta Neurological Clinic
3312 Piedmont Road
Atlanta, Georgia 30305*



REFERENCE COMMITTEE J

AS A RESULT of the disruption of the meeting of the American Medical Association in New York in July, 1969, the Board of Trustees of AMA decided to establish a special reference committee to obtain testimony from consumer and other groups who had requested such a hearing for the Chicago meeting, June 20-25, 1970.

Some of the groups requesting a hearing before the AMA House of Delegates were the People's Health Coalition, The National Welfare Rights Organization, The Ministry of Health in Philadelphia, The Medical Committee for Human Rights, Women's Liberation, The University of Chicago Center for Continuing Education, as well as a rash of individuals wishing to speak.

Many members of the American Medical Association called the formation of this Reference Committee a diversionary procedure to siphon off the so-called "special groups," so that an orderly meeting of the House of Delegates could be accomplished. Others thought the entire idea inappropriate in that the meeting evolved into a more-or-less-disorganized talk fest.

The meeting of Reference Committee J was held in the Monroe Room of the Palmer House, and although the number of people representing "consumer" groups was undetermined, I counted some 90 to 100 individuals who would fit into this category by either their activities, dress, or association with the groups on the podium. It had been announced that some 80 individuals and groups were invited to express their views. Each was to be allowed five minutes. However, with a program scheduled to last three hours, this, of course, was impossible!

Television, radio and other news media were exceptionally well-represented. As the meeting was called to order by the Chairman of the Reference Committee, Dr. Malcolm C. Todd, an individual rushed to the microphone and called for nominations of a permanent Chairman of the Floor. Although a number of names were called out, only one, that of Jim Wagner, a Negro, was considered. He was elected by acclamation by the consumer group, with a negative vote not even being called for.

The permanent, self-elected Chairman, Jim Wagner, then stated to the group of AMA Delegates and members in the room that to boycott the meeting would be to "abandon their own meeting." With the exception of noise, confusion, and constant uncertainty as to who had the floor, the meeting progressed without further incidence and no violence whatsoever.

The subject and line of discussion centered around the shortage of physicians, lack of allied health personnel, the right to medical care, lack of medical care to minority groups, high infant death rate, affluence of physicians in general, absence of medical care for the poor, use of indigents in mass experimentation, etc.

From the tone of the discussants, it was obvious that there is a deep misunderstanding of the American Medical Association's activities in general, and practicing physicians of the Association in particular, on the part of many segments of the public.

One Negro physician, George Tolbert, said he had practiced in South Carolina and Mississippi (presumably under O.E.O.), and began an impassioned plea for

the consumer group to cooperate with medical associations rather than attack them. He said that all agencies interested in health and medical care should form a coalition to provide good medical care for all segments of the population; whereupon he was summarily removed from the podium by a rather loquacious Negress who took the microphone, saying "the Doctor has requested that I speak for him because he is so emotionally involved and mentally upset."!

While this meeting was in full swing, the House of Delegates met behind a rather ominous blockade of police, security guards, and AMA staff members in the Red Lacquer Room without incident.

Personally, I felt certain in my own mind that these people and groups should have their say and should be heard, because much of what they do say should be added to the process of reason so that good medical care can be rendered to all segments of our population. As Speaker of the House, Russell Roth, said, "The business of this Association is important. If its orderly completion is made impossible through harassment by unrelated organizations, every legal recourse will be taken against them, for recovery of damages and for injunction against future disruptions. A meeting should not be conducted by the person who can shout the loudest."

Following the meeting, the Reference Committee made the following recommendations to the House of Delegates:

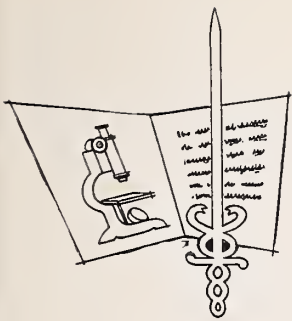
1. That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.
2. That consideration be given to the establishment of a reference committee to hear the views of consumer and other public groups concerned with health care at each Annual and Clinical Convention of the AMA.
3. That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients regardless of ethnic origin.
4. That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: "It is a basic right of every citizen to have available to him adequate health care" . . . and that "the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."
5. That the document submitted by the Parents League of American Students of Medicine Abroad, requesting changes in the requirements of American-born foreign medical graduates by the ECFMG, be referred to the Council on Medical Education.



F. G. Eldridge, M.D.
President, Medical Association of Georgia

Doctors have been exposed—you will always be exposed—to the attacks of those persons who consider their own undisciplined emotions more important than the world's most bitter agonies—those people who would limit, and cripple, and hamper research because they fear research may be accompanied by a little pain and suffering.

—Rudyard Kipling



QUALITY OF SURVIVAL

JOHN PAGE WILSON, M.D.,* *Atlanta*

EVALUATION OF END RESULTS has long been a criterion for the appropriateness and efficacy of treatment. Many aspects of disease can be documented statistically. The length of survival related to treatment and other factors can be recorded and statistically evaluated. There are, however, some factors reflecting the patient's welfare which cannot be easily reduced to numbers, charts and scales or even, at times, to universally comprehensible description. The basic elements of quality of survival, that is, the patient's comfort, happiness and usefulness, are such factors.

The comfort of a patient in the terminal stages of a disease and the care of the patient who survives treatment with serious physical or psychological limitations have always been problems for the physician. They have become progressively more common and difficult problems in recent years, particularly in the field of cancer.

The technical advances that have made it possible for pure "survival" have brought with them the necessity for evaluation of the nature or "quality" of survival.

There are two circumstances of cancer control in which the question of quality of survival is of paramount importance. The first includes patients in whom the possibility of cure requires an extensive and disabling procedure with serious physical and psychological consequences, and, secondly, the patient with inoperable cancer who may be a candidate for energetic treatment of the tumor.

The Potentially Curable Patient

*"It matters not how long we live, but how."
... Philip James Bailey*

Where curative procedures are associated with significant physical or psychological handicaps or deficits, the question arises, "To what extent can curative therapy be carried compatible with a comfortable, productive life?"

Some individuals, by the proposal and clinical use of progressively more extensive procedures up to and including hemicolectomy, have offered one answer. Some procedures, such as pelvic exenteration, which evoked considerable negative response two decades ago, are now generally accepted in principle and their feasibility has been limited only in terms of the possibility of cure and the adjustment of the individual patient.

To the physician the immediate pertinent questions are: Does a radical procedure have something to offer this patient, (1) by me? or, (2) by anyone?

These questions cannot be answered by an uninformed physician, and all physicians should have some knowledge as to the available procedures and results.

If one can define "radical surgery" as surgery resulting in significant physical, cosmetic or psychological deficit, it is apparent that a number of procedures fall into this category. For example, abdominoperineal colorectal resection is done by many surgeons. It is absolutely necessary that the surgeon assuming responsibility

* Chairman, Public Education Committee, American Cancer Society, Georgia Division, Inc.

for the patient have the necessary experience, skill and knowledge to do this, not only with morbidity, mortality and five-and-ten-year survival rates comparable to those available elsewhere, but also a rehabilitation program which will give the patient maximum restoration of usefulness and comfort.

The former, survival rate, can be evaluated only with continuing record-keeping and conscientious follow-up, preferably through a Tumor Registry.

The latter, rehabilitation, cannot be measured accurately by the usual follow-up methods. It requires knowledge on the part of the responsible surgeon, not only of what can and should be done to rehabilitate patients, but what is really being done for the patient and what has actually happened to the patient. The increasing activity of the enterostomal therapist has revealed the appalling conditions of many patients with colostomies and ileostomies. Some of this is due to an ignorance of what can be accomplished in the care of enterostomas, some is due to lack of interest and some due to failure of the patient to report the difficulties being encountered. All of these, however, can be corrected by the informed, concerned surgeon who follows his patients carefully, a responsibility that he assumes with the care of the patient.

Similarly the surgeon doing radical mastectomies must know and institute proper postmastectomy care; the laryngectomist must be prepared to see that the laryngectomees are taught how to speak.

There are other more difficult procedures requiring more extensive rehabilitative programs. Pelvic exenteration is a procedure which should be done only in those institutions which are qualified both in equipment and personnel and have the facilities to carry out the complete care of those patients from the beginning of therapy to rehabilitation. Hemicolectomy, probably the ultimate in planned resective surgery, is a procedure which probably should be carried out in only a few institutions in this country.

The physician must, to the best of his ability, decide whether the patient is a candidate for a surgical procedure. He must then carefully weigh the positive aspects of his care of the patient (convenience, financial aspects, personal interest and patient rapport) against the possible disadvantage. (Can this be done more safely or effectively elsewhere?) However, it must be emphasized that referral to a specialty center does not relieve the primary physician of his decision-making. Referral to a center may be a therapeutic commitment, *per se*, for the fact that the patient has been referred to the center is often a significant factor in the decision to proceed with radical surgery.

340 Boulevard, N.E.

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THE SIGNIFICANCE OF ELEVATED BLOOD PRESSURE IN THE YOUNG

JOSEPH A. WILBER, M.D., *Atlanta*

MANY PHYSICIANS have had the occasion to examine groups of young adults between the ages of 15 to 24 for high school or college athletic activities, ROTC or military service. A common finding is so-called "labile hypertension." This is thought to be a benign finding attributed to anxiety or nervousness and it is expected that with maturity most of these individuals will have a normal blood pressure. Rarely are these individuals followed closely and almost never are they treated with anti-hypertensive drugs. Conversely, many individuals with sustained hypertension in their 30s or 40s give a history of elevated blood pressure at the time of college or service physical examinations, 10 to 20 years prior to the "discovery" of their well-documented hypertension. Does essential hypertension really begin in the teen ages?

In the September 15, 1969 issue of the *Journal of the American Medical Association*, an important and startling paper appeared entitled "Elevated Blood Pressure Levels in Adolescents, Evans County, Georgia. A Seven-Year Follow-up of 30 Patients and 30 Controls," by Hayden, Bartel, Hames and McDonough.

In 1961, nearly the entire population of this county underwent an extensive history, physical, and laboratory examination conducted by a U.S. Public Health Service medical team. One of their findings was that 11 per cent of the teenage population (ages 15 to 25) had an average systolic blood pressure of 140 mm Hg or greater, or diastolic of 90 mm Hg or greater, and no evidence of renal or other disease.

In 1968, this same population was reexamined in a similar fashion. Thirty of the original 50 young "labile hypertensives," now age 23 to 33 years of age, were available for follow-up examination. Seven of these 30 still had borderline hypertension, five now had sustained hypertension greater than 160/95 but without complications, four had sustained hypertension with cardiomegaly, proteinuria and/or abnormal electrocardiograms and two were dead, both of cerebral hemorrhage. Only 12 of the original 30 had become normotensive. For a control group, the authors retrospectively chose 30 normotensive controls matched by age, sex and race from the 1961 study. Re-examination of these controls showed that only four had developed mildly elevated blood pressure by 1968 and all of these were without complications.

The authors concluded "the clinical significance of elevated blood pressure in adolescence needs to be emphasized. This follow-up study extended over a seven year period during which none of the 30 individuals were treated. It is suggested that, if they had been under constant medical care, the outcome of the study might have been different."

In view of these findings, what should the physician do when he discovers a teenager or young adult with blood pressure levels in the 140-150/90-95 range? Certainly such a person should be followed closely with examinations at least once a year. If the adolescent is also obese, strenuous efforts to reduce body weight

should be strongly advised. If the blood pressure rises above 160/95 during the follow-up, treatment with drugs should be begun. Usually a chlorothiazide diuretic will lower the blood pressure quickly and without unpleasant side effects.

Many young adults migrate geographically and are easily lost to follow-up. The physician, therefore, is obligated to tell the patient of his findings and prognosis and to impress upon him the asymptomatic nature of this "silent killer." He should urge him to have yearly examinations no matter where he is or how he feels. At the same time he can encourage the patient by describing the effectiveness of current therapeutic agents and explaining the possibility of a spontaneous return to normal pressure levels with increasing age.

615 Peachtree St., N.E.

Total abstinence varies in different communities. South of the Mason and Dixon line a mint julep, a toddy, or a cocktail before meals or between, is total abstinence; and a profusion of egg-nogs at Christmas a necessity.

—Sir William Osler



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals. The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients

and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction. Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy. We will be pleased to provide further information upon request.

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NEW FEDERAL AND STATE GARNISHMENT LAWS

ORINDA D. EVANS, *Atlanta**

ALL GEORGIA EMPLOYERS, including hospitals and physicians, will be affected by new federal and state garnishment laws which became effective on July 1, 1970. The new laws basically (1) restrict to a greater extent than previously the amount of an employee's wages which may be subject to garnishment, and (2) prohibit the discharge of any employee because his earnings have been subjected to garnishment for any one indebtedness.

Garnishment is a method of debt collection. Generally, an employee's wages may be garnished when a creditor has obtained a judgment against him. A summons of garnishment may be served on his employer, which requires the employer to retain and accumulate the non-exempt portion of the employee's wages during a certain required period¹ and to send these funds to the court when answer of garnishment is made. Failure to make timely and correct answer of garnishment has heretofore meant that the employer-garnishee may be held liable for the entire amount of the judgment against his employee.

Past Georgia law provided that \$3.00 per day of an employee's wages plus 50 per cent of the excess remaining after deduction of the daily exemption is exempt from garnishment. On July 1, 1970, the repeal of this law became effective and the non-exempt portion of an employee's wages must be computed in accordance with provisions of the new laws.

The new federal law on garnishments is a part of the Consumer Credit Protection Act, 15 U.S.C.A. §1601-1677. Sub-chapter II of the Act deals with restrictions on garnishments, including restrictions on garnishable amount. It will be enforced by the Wage and Hour Division of the Department of Labor. The new Georgia law on garnishments, Ga. Laws 1970, No. 1324 (S.B. No. 14), contains a provision restricting the amount of wages subject to garnishment which is substantially the same as that of the federal Act.

Maximum Garnishable Amount Under the New Laws

The maximum amount which may be garnished from an employee's wages under both the new Georgia and federal laws is 25 per cent of his "disposable earnings for the week" or "the amount by which his disposable earnings for that week exceeds 30 times the federal minimum hourly wage,"² whichever is less. "Disposable earnings" is defined as "that part of the earnings of any individual remaining after the deduction from those earnings of any amounts required by law to be withheld."³

1. This period varies in different counties and in different courts from which summons of garnishment must issue.

2. For purposes of this computation, the applicable minimum wage will be \$1.60 an hour, regardless of whether the particular employee is exempt from the minimum wage provisions of federal law or whether the \$1.60 minimum wage standard is not applicable to his employer's business.

3. There may be some federal regulations later which will add refinements to this part of the federal law. Your attorney should be consulted in this regard and with respect to individual garnishment problems.

* Prepared at the request of the Medical Association of Georgia. Miss Evans is associated with the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

This means that in calculating the garnishable amount of wages for a pay period, it is necessary first to subtract from gross wages for the pay period all taxes, including social security, which state or federal law requires to be withheld. The net amount thus obtained is an employee's "disposable earnings." To determine the amount subject to garnishment, "disposable earnings" for the pay period in question are multiplied times .25. It is then necessary to check to see whether the amount by which the employee's "disposable earnings" for the pay period exceeds 30 times the federal minimum hourly wage for each week in the pay period is a smaller amount. The lesser amount will be the amount subject to garnishment for one pay period.⁴

The net effect of this part of the new laws is to increase drastically the garnishment exemption for wages, particularly in the case of those employees earning close to the minimum wage.

Other procedural matters relating to answering a summons of garnishment have not been changed by the new federal or state laws. The time for answering the summons of garnishment, which is printed on the summons, remains the same.

The foregoing restriction on garnishable amount applies only to garnishment of wages. In addition, the new federal law provides that there shall be no exemption from wages which are subject to garnishment in the following types of cases:

- (1) Any order of any Court for the support of any person;
- (2) Any order of any Court of bankruptcy under Chapter XIII of the Bankruptcy Act;
- (3) Any debt due for any state or federal tax.

Prohibition of Discharge

The second important change made by the new federal and state garnishment laws is that, effective July 1, 1970, an employer may not discharge an employee because his earnings have been subjected to garnishment for any one indebtedness. The penalty for willful violation of this part of the federal law is a fine of up to \$1,000.00 or imprisonment for up to one year, or both. Violation of the Georgia law prohibiting such discharge is punishable as a misdemeanor.

An employee may not be discharged for successive garnishments on one indebtedness. However, an employer may, if he so desires, discharge an employee for garnishments for more than one indebtedness.

New Protection for Garnishees and Garnisheed Employees

In addition to the restriction on garnishable amount and the prohibition of discharge because of garnishment for an indebtedness, the new Georgia Act provides some relief for the defaulting garnishee, who under present law is liable for the entire amount of the judgment against the defendant. The new law allows a garnishee against whom a default judgment has been taken to have the judgment against him modified (this must be done no later than one year from date of recording of the judgment) so that the amount of the judgment is reduced to 125 per cent of the amount which the garnishee would have had to answer into court had he done so properly. However, the reduction thus made may not reduce the amount of the judgment below an amount equal to 15 per cent of the principal judgment against the defendant. Therefore, it is still important for a garnishee to make timely and correct answer of garnishment.

The new Georgia Act also contains some provisions which are designed to give some protection to debtor-defendants. It is provided that the bill of costs in garnishment proceedings shall not exceed one-fifth of the indebtedness collected

4. The computation must, of course, be made for each pay period within the period covered by the garnishment.

by garnishment. In addition, the Act provides that an employee whose wages are subjected to garnishment upon a default judgment and who has not had "prior actual notice" of the default may, upon proof of "excusable neglect" with respect to the default of answer to the complaint, vacate the judgment. The motion to vacate must be made within 15 days of the date of service of summons of garnishment upon a garnishee and within two years of the date of the default judgment. Court costs incurred under the judgment, garnishment and motion to vacate must be paid by the employee-movant.

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HIGHLIGHTS OF THE AMA HOUSE OF DELEGATES MEETING

The 119th Annual Convention of the American Medical Association was held in Chicago, June 21-25. The following summary covers many of the subjects considered by the AMA House of Delegates. It is not intended as a complete report of all actions taken.

In its first uninterrupted Annual Convention since 1967 (thanks to the most elaborate security precautions ever taken), the House of Delegates considered a record volume of business; passed a hotly debated statement on abortion; raised membership dues to help finance needed programs; heard outgoing President Gerald D. Dorman challenge the Association to attain and maintain a specific minimum health standard of "a healthy child and a healthy mother."

House Actions

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports—31 from the Board, three from the Judicial Council, six from the Council on Constitution and Bylaws, 10 from the Council on Medical Education, five from the Council on Medical Service, and six special reports. It also dealt with 140 resolutions—eight un-numbered memorial or commendatory ones, 27 special ones generated by the (Himmler) Committee on Planning and Development, and 105 from regular sources.

Abortion

After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, The standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical

practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his State; and be it further

"Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

Dues Increase

Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility.

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by \$40, to \$110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

Planning and Development

One of the longest debates of the meeting involved creating a body for long-range planning and development. When the matter was settled, a standing committee of the House—the Council on Long-Range Planning and Development—had been created and the bylaws had been changed appropriately to accommodate it.

The House also acted on the recommendations of the earlier Committee on Planning and Development

HIGHLIGHTS / Continued

(Himmler committee). Here are some of the recommendations adopted by the House:

1. That the AMA reaffirm, as a statement of the primary purpose and responsibility of the Association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make medical services of high quality available to all individuals.

2. That the Association has the duty to guide and assist the medical profession in the attainment of this objective.

3. That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

4. That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

5. Health is a state of physical and mental well-being.

6. That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

7. That the Association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the

fact that these shortages are not due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

8. That an appropriate Committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

9. That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

10. That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

11. That the Association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

12. Encourage state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

13. That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective

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for the consideration of fees and the costs of medical and related care.

14. Endorse the principle of voluntary, life-long postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

15. That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing officers.

Professional Liability

The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association. . . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

Nursing

The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

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Drugs

The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manufacture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal or modify "anti-substitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of anti-substitution laws and regulations."

Miscellaneous

Approval was given to a report of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physician to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physi-

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HIGHLIGHTS / Continued

cian to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take what-

ever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Elections

Wesley W. Hall, Nevada, was elected President-Elect, and will become the 126th President of the AMA in June, 1971.

H. Thomas McGuire, Delaware, was elected Vice President and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected to their posts as Speaker and Vice Speaker of the House, respectively.

G. LOMBARD KELLY—A MAN TO REMEMBER

ROBERT B. GREENBLATT, M.D., *Augusta*

Dr. Lombard Kelly, one-time professor of anatomy, Dean of the Medical College of Georgia, and later its president, is with us still. Enfeebled by the ravages of time, he approaches his 80th birthday, full of years and serenity. As we enter the decade of the '70's, let us pause, look back, and recall a man to remember. It is timely, too, to apprise a new generation of physicians who were not privileged to know him, of how much we, the medical community, are in his debt. I write as I remember him, and the impossible dream that he nurtured and saw to fruition.

The Flexner survey of the medical colleges of the United States, completed in 1910, asserted, "the Augusta situation is hopeless, there is no possibility of developing there a medical school controlled by the University. The site is unpropitious, the distance too great. The University should snap its slender thread; the medical school will not long survive amputation."

The college weathered the storm and continued in comparative quietude until early in the 1930's. Then the heavens fell in, the Council on Medical Education removed its accreditation; the Associations of Medical Colleges placed the school on probation; the Board of Regents felt it could no longer continue its support; political pressure demanded either closure or removal of the school to Atlanta.

What were the options? The demise of a proud institution that served the people of the state for over 100 years, or a fight for its continued existence. Dr. Kelly, with the unflinching support of the highly respected Dr. Virgil Sydenstricker, convinced the authorities that the school was worth saving, and with the appointment of Dr. Kelly as Dean in 1934, the battle for survival was joined. Admittedly, the school had been allowed to run down, there was too much complacency, inbreeding, and nepotism. The Hercule-

an task of cleansing the Aegean Stables fell squarely on Dr. Kelly's shoulders. The challenge was accepted with characteristic "bulldog" tenacity and he set on a course to win. He visited every county medical society that would hear him. He wrote each alumnus, asking for donations, and urged that each exert his influence with the solons of the state for increased financial involvement.

Academic aspects, in the meantime, were not neglected. Kelly took immediate steps to revitalize the faculty by recruiting over a dozen top notch men from various parts of the country, and instituted a program of research fellowships. The library was remodeled and updated. The Milton Antony wing was added to the University Hospital to meet the needs for a complete outpatient department and to provide beds for contagious diseases. The Dugas building, for biochemistry, physiology and pharmacology, was completed and plans laid for the Murphey building to house pathology, microbiology and public health. As a result of all this activity, the political pressure to move the school was thwarted and the college's Class A rating was restored. Kelly now had visions for a great medical center in Augusta and exacted a promise from the then governor of the state, the Hon. Eugene Talmadge, to build a great teaching hospital on the campus.

In the immediate years that followed, student enrollment was markedly increased. To the faculty, which now included such giants as Sydenstricker in Medicine, Hamilton in Physiology, Sanderson in Bacteriology and Public Health, Pund in Pathology, Krafka in Histology, a group of new members was added. Perry Volpitta organized the Department of Anesthesiology; Richard Torpin brought new vitality to the Department of Obstetrics and Gynecology; the late Robert Major started one of the first departments for Pulmonary and Cardiac Surgery, and Hervey Cleckley set up a Department of Psychiatry. The school

Reprinted from the Bulletin of the Richmond County Medical Society.

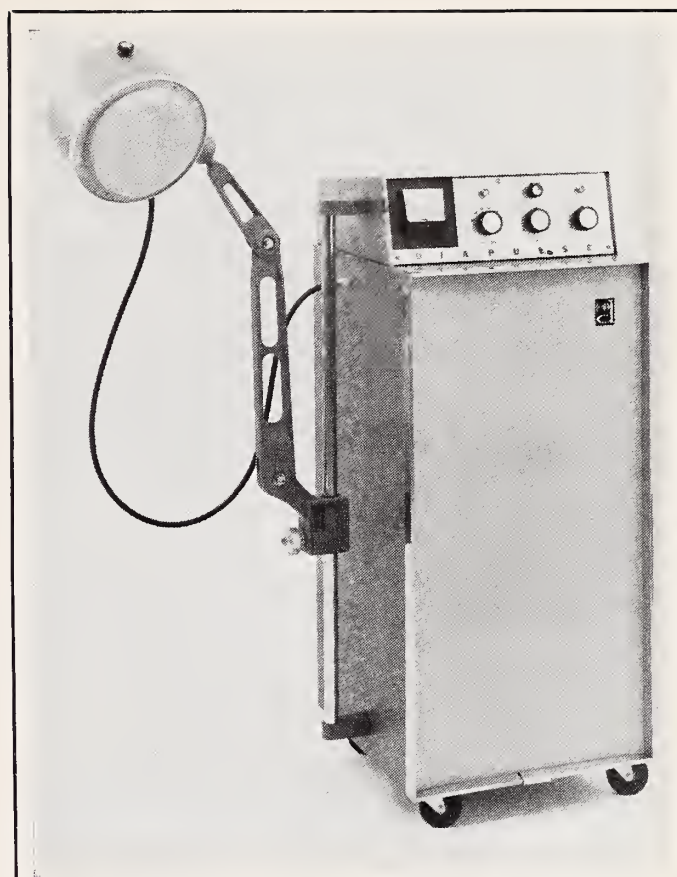
soon attracted excellent men such as Ray Ahlquist in Pharmacology, Philip Dow in Physiology, Sam Singal in Biochemistry and Robert Rinker in Urology to mention but a few. Finally, with plans approved for the erection of the Eugene Talmadge Memorial Hospital, Dr. Kelly felt that his goal and his dream was realized. In 1953, at the age of 63, he relinquished his position as president so that he might spend a few years in private practice devoted to the management of sexual difficulties in marriage. Incidentally, Bob Deinst, famed for his contributions to the microbiology of the minor venereal diseases, remains the sole reminder of the nucleus that joined the faculty in 1934, and Harry Harper and I are the surviving remnant of the original four research fellows.

In the annals of the Medical College, one man stands taller than all the rest. Lombard Kelly saved the school, fostered harmony and contentment among his underpaid but loyal faculty, gave each chairman complete autonomy and provided him with a feeling of genuine trust and security. He prepared the way for the great medical complex now in the making. His vision has become a reality.

What kind of man was G. Lombard Kelly during his active years? He was affectionately called "The Great Stone Face." The students found in him a friend to whom they could go for advice and help. He was a compassionate man who saw the side of goodness and kindness in every soul. He was a scholar; his use of the English language was precise and impeccable. He was a scientist. His studies with Papanicolaou, on the opening of the vaginal canal following estrogen administration to immature guinea pigs, were a milestone in experimental endocrinology. These were the studies that indirectly led to the now famous "Pap" test for cervical cancer. He was a medical diplomat, for during his stewardship "town and gown" worked in unity. He was a courageous innovator, for he lectured on "sex" to medical student and physician alike at a time when his confreres still regarded the subject as distasteful. His "Sex Manual" has been reprinted 23 times and has sold over one million copies. The booklet was written not so much for gain as it was to share his knowledge for a better understanding of the sexual act. He was indeed an evangelist in this field of human behavior. Lombard Kelly was the quintessence of kindness, the epitome of the gentle man. He was, nonetheless, an intrepid adventurer with the faith, courage, and endurance to overcome the obstacles that beset his path. Though he liked to think of himself as an agnostic he has been, in his own way, a religious man—one of the most Christian-like men I have ever known.

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Benitez, Oswaldo D. Active—T-B-G—SU	Quitman, Georgia 31643
Blumenthal, Jerome B. Active—Cobb—I	638 Church Street Marietta, Georgia 30060
Brantley, Edmund B. Active—Fulton—R	300 Boulevard, N.E. Atlanta, Georgia 30312
Cook, Dana F. Active—Fulton—Anes	Emory University Hospital Atlanta, Georgia 30322
Corder, V. Woodard Active—Fulton—Anes	573 W. Peachtree St., N.E. Atlanta, Georgia 30308
Demby, Charles E. DE-2—Fulton—SU	300 Boulevard, N.E. Atlanta, Georgia 30312
Fussell, Daniel O. Active—Peach Belt—I	212 Hospital Drive Warner Robins, Georgia 31093
Gomez, Francisco D. Active—Baldwin—OR	Central State Hospital Milledgeville, Georgia 31062
Gordon, Stephen F. DE-2—Fulton—OBG	Penn. Hospital Philadelphia, Pa. 19100
Harvey, David N., III Active—Peach Belt—PD	212 Hospital Drive Warner Robins, Georgia 31093
Johnson, Jimpsey B. Active—Richmond—R	Medical College of Georgia Augusta, Georgia 30902
Marschalk, Frederick F., Jr. Active—Richmond—I	Talmadge Memorial Hosp. Augusta, Georgia 30902
Meeks, William H. Active—Richmond—NS	Talmadge Memorial Hosp. Augusta, Georgia 30902
Mills, Luther R., IV Active—Richmond—Path	Medical College of Georgia Augusta, Georgia 30902
Nutter, Donald O. Associate—Fulton—I	69 Butler Street, S.E. Atlanta, Georgia 30303
Weiss, Harvey A. Active—Fulton—PI	275 Carpenter Drive, N.E. Atlanta, Georgia 30328
Whidder, Desiderius C. Active—Fulton—Su	490 Peachtree Street, N.E. Atlanta, Georgia 30308

SOCIETIES

The **Fulton County Medical Society** sponsored a free nine-hour course of instruction and practice in the techniques of mouth-to-mouth resuscitation and external heart compression in July.

The **Georgia Medical Society**, in cooperation with Savannah's Community Cardiovascular Council, has approved a study of heart disease and stroke rate in Savannah by Johns Hopkins University.

The **Hall County Medical Society** is seeking use of that county's Model Cities funds to improve effectiveness of the medical staff's services to Model Cities residents.

PERSONALS

First District

Manuel Merida, a former staff member of the Claxton Hospital in Dublin, has moved his practice to Baxley.

Third District

Dan Callahan has been elected chairman of the executive committee for the Atlanta Regional Red Cross Blood Program.

Fourth District

Ben H. Jenkins has been elected to the governing board of Woodward Academy, in College Park.

Fifth District

Dale E. Dominy spoke on smoking and drugs at the June meeting of the Hampton Kiwanis Club.

Alfred Joseph has been named Chief of Medical-Dental Staff for South Fulton Hospital.

An exhibit on cancer research, being carried on by **Drs. Zuher M. Naib, Andre J. Nahmias and William E. Josey**, won honorable mention at the annual meeting of the American Medical Association.

Sixth District

George Franklin Green has been re-elected to active membership in the American Academy of General Practice.

Frank M. Houser has been re-elected to active membership in the American Academy of General Practice.

Seventh District

Ross Whatley spoke on medical developments in the field of heart trouble diagnosis and treatment to the Cartersville Rotary Club in June.

Eighth District

Richard L. Benson wrote an article on exercise in the prevention of arteriosclerotic heart disease, which was featured in *The Douglas Enterprise* in June.

Carl Drury has qualified for Representative from the 66th District to the Georgia General Assembly.

Walter E. Lee has been re-elected to active membership in the American Academy of General Practice.

Ollie O. McGahee and **Robert A. Pumpelly** have been nominated as diplomates of the American Board of Family Practice.

Ninth District

Robert E. Thompson has been nominated as a diplomate of the American Board of Family Practice.

DEATHS

Ralph Butler McCord

Ralph Butler McCord, 63, died June 24 in a Rome hospital.

A native of Whigham, he was a graduate of Emory University and Emory University Medical School.

Dr. McCord was a member of the Floyd County Medical Society, Medical Association of Georgia, American Medical Association, and the First United Methodist Church, where he was active in the church choir. He was a veteran of World War II.

Dr. McCord is survived by his widow, the former Jane Miller; two daughters, Mrs. Eldon Wallace of Jefferson City, Mo., Miss Jane McCord of Rome; two sons, Ralph McCord, Jr., and John Miller McCord of Rome; one brother, Malcolm McCord of Selmer, Tenn.; one sister, Mrs. Fred Snell of Rome, and stepmother, Mrs. M. M. McCord of Rome.

Charles K. McLaughlin

Charles K. McLaughlin died June 16 in an Atlanta hospital. He was 62.

Born in Chatham County, Dr. McLaughlin lived in Macon for 36 years. He was a member of St. Joseph Catholic Church.

Survivors include his widow, the former Mary Bischoff of Macon; three daughters, Mrs. Robert Bonifau, Mrs. Howard Hailey, and Miss Fran McLaughlin, all of Atlanta; three grandchildren; one sister, Miss Margaret McLaughlin of Savannah; two brothers, John McLaughlin of Savannah and Francis McLaughlin of Gainesville.

Lovick W. Pierce

Lovick W. Pierce, 68, died June 28 in a private hospital in Atlanta.

A former chief of staff at Memorial Hospital in Waycross, he was also a past president of the Ware County Medical Society and a member of the American Board of Urologists and the Waycross First Methodist Church. He was a graduate of Emory University and Emory Medical School.

Dr. Pierce is survived by his widow, a son, two daughters and four sisters.

John B. Thompson, Jr.

John B. Thompson, Jr., died July 6 at the age of 68.

Born in Cochran, Ga., he was graduated from Emory University Medical School. He then trained at Presbyterian Hospital in Chicago and Wise Sanitarium in Plains, Ga.

During World War II, Dr. Thompson served as a captain in the Army Medical Corps in North Africa. In 1967, he served as a volunteer on the hospital ship HOPE.

Dr. Thompson is survived by his widow, the former Marie Dykes; one daughter, Mrs. William B. Turner, and son, John Daniel Thompson, M.D., of Atlanta.

THE MONTH IN WASHINGTON

An American Medical Association proposal for peer review for the medicare and medicaid programs drew favorable reaction from members of the Senate Finance Committee.

Peer review was one part of a three-point program which Dr. Gerald D. Dorman, the outgoing president of the AMA, offered in testimony at a Senate Finance Committee hearing on medicare and medicaid.

Dr. Dorman and Dr. Julius W. Hill, president of the National Medical Association, testified together. They jointly urged on behalf of their organizations that Congress replace medicaid with a national health insurance program subsidized by the federal government.

The AMA health insurance proposal, which initially was approved by the AMA House of Delegates in 1968, was similar to the plan President Nixon included recently in his proposed revised new national welfare program. He said he would send such legislation to Congress early next year.

Congress is not expected to take up this year proposals for national health insurance, but reaction to the peer review proposal was highly encouraging. Prospects for Congressional approval this year appeared good. Sen. Wallace F. Bennett (R., Utah), a finance

committee member, directed the committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising medicare and medicaid.

Joint Testimony

The presidents of the AMA, with 223,000 members, and the predominantly negro NMA gave assurances at the finance committee hearing of the medical profession's cooperation in solving the nation's health care problems. It was the first time that spokesmen for the two leading medical associations had testified together before a Congressional committee.

Dr. Dorman said "the medical profession hopes to see the nation pursue" the three-point program in efforts to provide quality health care for everyone as economically as possible.

Dr. Hill said the insurance plan would work better than medicaid in the ghettos. He also defended physicians against accusations that they have been profiteering under medicaid and medicare.

AMA Program

The first two parts of the AMA program comprised the association's "medicredit" health insurance

plan. The third, peer review, "is a way to assure both scientific quality and economic reasonableness in the medical and health care people get," Dr. Dorman said.

"Our first program would meet the problems of the Title XIX medicaid program," Dr. Dorman said. "Under our plan, each low income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The protection would be theirs without expense or contribution since the cost of the program would be borne entirely by the federal government.

"The second offers tax credits, on a sliding scale based on the tax liability of a family, for the purchase of qualified health benefits coverage. For those with moderate or higher levels of income, the program would provide cash incentives, through income tax credits, to encourage them to protect themselves against major health care costs.

Structured Peer Review

"The third part of our program calls for a structured peer review mechanism to insure high quality of care and to prevent abuses of the medicare and medicaid programs."

Dr. Dorman noted that the committee's staff in a report last February on medicare-medicaid suggested that organized medicine regulate itself.

"We agree, and propose a program providing for professional review of matters bearing on reasonableness of charges for, need for, and the quality of services rendered by, the provider of medical or other health services," he said.

Cost Concern

In a speech on the Senate floor, Bennett said there is deep concern over the high costs of medicare and medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I believe the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly—proposes to do something substantial about it through means of professional standards review organizations. . . .

"I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake: the direction of the House-passed social security bill is toward more—not less—

review of the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

Review Responsibility

Bennett said that, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility he said, would be lodged, "wherever possible and wherever feasible," at the local community level. He said:

"Local emphasis is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review. . . .

"Under the amendment, the Secretary (of Health, Education and Welfare) could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only *pro forma* or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

Bennett said that the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

Disciplinary Measures

Disciplinary measures, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

Dr. Hill directed his testimony before the finance committee mainly to medical care of the blacks and other poor people, particularly in ghettos. He took issue with the committee staff report which, he said, "by implication attacked the very physicians working closest to the poor and treating them." He said restrictions upon physicians' fees, as advocated in the

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report, would make more acute the already critical shortage of physicians in ghettos.

"To those who read the entire report, there were a number of very complimentary things said about all physicians," Dr. Hill said. "But the primary message, the one seized upon by the press and broadcast across the country, appeared to be that any doctor earning a substantial amount of money from medicare-medicaid was somehow cheating both the government and his patients.

"It was bitterly ironic. To work 60 and more hours a week in the ghetto, and to be fairly paid, was suddenly *prima facie* evidence of wrong-doing.

Physicians Blamed

"The report was also interpreted so that the blame for the rising cost of medicare-medicaid was directed at the physician—and particularly those caring for the poor.

"Therefore, we of the National Medical Association take strong exception. The implications and accusations of that report were grossly unfair. It is difficult enough to get physicians to practice among the poor. . . . If these men, professionals committed to providing care, are to be subjected to irresponsible accusations for the size and success of their ghetto practices, it will very soon be impossible to find a doctor among the American poor."

The association showed the senators a brief movie of physicians practicing in a Chicago ghetto health center and in an Appalachian community clinic.

No Polio Deaths

The National Communicable Disease Center of the U. S. Public Health Service said that not a single death from polio was reported in the nation last year.

It was the first time no death from the disease was reported since 1955 when regular polio surveillance was started. In addition to the absence of a death, the total number of cases of paralytic polio was only 19.

Before the introduction of polio vaccine during the mid 1950's, annual paralytic cases went as high as 21,300 with 1,400 deaths. The number of cases began to dwindle after use of the vaccine became widespread and 1960, with 230 cases, was the last year when the number of deaths exceeded 100. In recent years, the death toll usually has been between 10 and 20.

Among the 19 paralytic cases last year, only one occurred in a person who had received a full series of anti-polio doses. The exception was a two-year-old suffering from an inborn inability to form protective antibodies against bacteria and viruses.

An estimated 26.5 million doses of vaccine, most of it the oral type, was administered nationwide last year.

A federal health official warned that small outbreaks of polio still are possible in city slums and other areas where it is difficult to achieve 100 per cent immunization. There already have been 11 known cases and one death in the Rio Grande Valley citrus growing region of Texas where there was a problem of convincing parents of the need for immunizing.

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See Page 351

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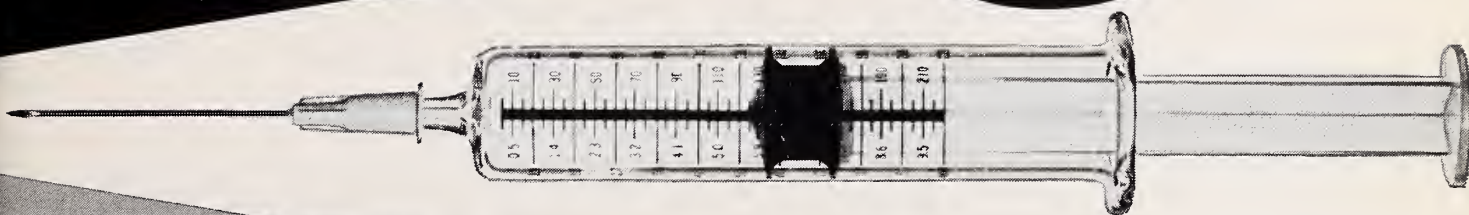


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Contents

Special Articles

BENEFITS OF VIGOROUS PHYSICAL ACTIVITY FOR YOUNG BOYS

Clyde Partin, Ph.D. 351

A PRACTICAL, PALATABLE AND PRUDENT WAY OF EATING

Ancel Keys, M.D. 355

Scientific Articles

ACUTE INTERMITTENT PORPHYRIA

Albert A. Carr, M.D., and J. Larry Sanders, M.D. 360

CHEMOTHERAPY IN PRIVATE PRACTICE

John Trice, M.D. 365

Editorial

MEDICAL ASPECTS OF SPORTS 369

Features

President's Letter 370
Heart Page 372
Legal Page 375
Month in Washington 380

The Association

New Members 378
Societies 378
Personals 378
Deaths 379

Cover

Photograph by Edgar Woody, Jr., M.D. Layout by Marie Seaman.

By incorporating a carefully graded program, this type of activity may be highly beneficial and safe for young boys.

Benefits of Vigorous Physical Activity for Young Boys

CLYDE PARTIN, Ph.D.,* *Atlanta*

WE ARE LIVING in a fast moving society. All systems are on "go." The word is activity, movement, action, exploration. In order to keep up with this society the individual must be prepared to enter it fully armed. The weak will fall by the wayside.

For example, we are a nation of "meeters." The number of meetings held and committees formed, and the number of committee meetings held in this country, if known, would most certainly stagger our wildest imagination. Surely more time has been spent in meetings in our city regarding proper pick up and disposal of garbage than the Continental Congress spent in discussing the really important issues of the day during their time.

We are a nation of "doers," "organizers," and "activists." If something needs to be done we do it. If existing organizations are there for us to carry out our plans we utilize them. If not, we form new organizations. We elect officers, appoint more committees and get the job done. Age, time, distance, money doesn't seem to slow us down.

In short, if a job is given to us, we do it. The American people are competitors and to compete is a very natural part of our lives, be it in business, the professions, or sports. Millions of people take part annually in many different activities and millions of dollars are spent in sports and recreational activities.

Yes, we are active people. But, are we active enough in the right way?

Why do we have over 50 per cent of our population dying of some form of heart disease? Why are we still a nation of smokers? Why do we have literally millions of people on diets? Why do we produce

eight billion pep pills per year? Why are we a nation dependent to such a large degree on pills and tranquilizers? I am certain there are many answers to the above questions, but it is not within the scope of this paper to attempt to answer them.

Passive Activity

However, I would submit for your consideration one possible simple answer, and that is that we are simply not active enough where it counts. Our activity for the most part is too passive, too sedentary. We must promote vigorous physical activity if the desired results are to be obtained.

"Heart disease is a pediatric disease the treatment of which should begin during early childhood," Dr. John L. Boyer, medical director of the Human Performance and Exercise Laboratory in San Francisco, told the 21st Annual Meeting of the American Academy of General Practice. He said the coronary disease-prone middle-aged adult is "the end product of a condition that began in childhood."

Boyer believes that children should begin health habits which would help control body weight, decrease intake of saturated fats, abstain from cigarette smoking and learn physical activity that can be enjoyed for an entire lifetime, beginning at a very early age. Boyer noted that hiking, jogging, swimming, cycling, running, canoeing and other similar activities are good for promotion of cardiovascular fitness.

School Programs Insufficient

Well, you say, surely boys get enough activity in school every day. *Don't count on it.* Then, you say, certainly they get plenty of activity in after school activities. *Again, don't count on it.* Well, then, you say, certainly they must get it in community organized little league baseball, Pop Warner Football

* Chairman, Division of Physical Education and Athletics, Emory University.

ACTIVITY / Partin

programs, or Youth League Soccer, not to mention Iddy-Biddy Basketball or Silver Mittens. *Again, I say don't count on it.*

Now, you say, wait a minute, you started out talking about deaths from heart disease, smoking, pep pills, etc. and now you move into condemning little leagues and their counterparts. True, I did mention death rates from heart diseases, etc. and I did say that as far as sufficient vigorous physical activity is concerned you will not usually find it in the school, after school, or little league-type program. Now, you may say—well, it isn't the purpose of the school or the little league to promote vigorous physical activity.

Change in Purpose

So, now we come to the point of my talk. I submit to you that if vigorous physical activity is not one of the purposes of little league, there should be a change in purpose. Playing baseball is fun, and that is as it should be, but my thesis is that you can make it more fun and do a better job for the boy by having him (and you) engage in vigorous physical fitness sessions before your practice sessions. If this means spending less time on fundamentals, then spend less time on fundamentals. You know and I know that most little leaguers are "overcoached" anyway. In short, physical fitness first, fundamentals second, and play the game third. It is not difficult for you as a coach to learn enough about physical fitness activities to carry on a good well-rounded meaningful program. Remember, you are not only building physical fitness at the moment but, more importantly, are helping to establish proper attitudes and habits toward fitness. It has been shown that about one-half of normal school learning is acquired by about age nine. It is imperative, therefore, that attitudes and habits relating to fitness be established during the first nine or 10 years of a child's life. And, you know as well as I do the "esteem" in which most coaches are held. Therefore, you can take advantage of this wonderful opportunity to promote physical fitness among your young charges.

Improve Fitness

What can you do specifically to make your boys more fit? Of course, there are numerous exercises and many areas in which one might concentrate. I would recommend three areas to you:

I. Strength—the amount of force a muscle can exert against a resistance.

II. Flexibility—the ability to move the limbs around a joint through their full range.

III. Cardiovascular Endurance—the ability of

the heart and lungs to respond adequately to exercise.

In terms of specific exercises for each of the areas, I would recommend the following:

I. Strength Exercises

1. Pull-ups—Grasp the bar, palms away from the body. Pull up until the chin rests over the bar. Lower yourself until elbows are locked out, then repeat as many times as possible.

2. Push-ups—This exercise develops strength particularly in the arms and shoulders. Twenty push-ups from the floor is a desirable objective to work toward. Intensity may be increased by exercising faster and for a longer period of time. Perform one cycle in two seconds; down on count one and up on two.

3. Medicine Ball Exercises—Many routines may be used. One is simply passing the ball in a two-hand chest pass back and forth.

4. Wall Press—Stand erect with the back against a wall, and press the palms against the wall as firmly as you can. This exercise will help develop abdominal and upper-arm muscle groups.

5. Palm Press—Stand and press one hand against another, first to the right, then to the left, and then with the palms together, fingers pointing downward. Hold each position six seconds. This exercise is good for development of chest, arms, and abdomen.

II. Flexibility Exercises

A person should possess a satisfactory degree of flexibility because:

1. a greater range of joint motion results in better sports performance.

2. flexibility acts as a precautionary measure against damaging muscle fibers.

3. a proper amount of flexibility is some insurance against developing low back pain or muscle tension across the shoulders and throughout the neck region.

Flexibility Exercises

1. Standing Bobbing—Place the feet astride and bend at the waist, with the knees straight and the arms and head hanging loosely. As you bob, concentrate on relaxing the muscles and try to touch the floor. This exercise is good for stretching the muscles of the upper back, buttocks, and upper and lower legs. The ability to touch the fingertips to the floor with the knees straight signifies a satisfactory degree of flexibility for the muscles involved.

2. Sitting Bobbing—Sit on the floor with the feet spread and reach first for one foot, then the other. Each time you bob, attempt to touch the

head and chest to the thigh of the foot for which you are reaching. Although this exercise develops flexibility in the same muscle groups as does standing bobbing, it places more emphasis on stretching the upper back muscles. The ability to reach the feet indicates sufficient flexibility of the upper back.

3. **Back Stretch**—Lie face down, with the feet straight and the arms spread. Raise the chest from the floor. Concentrate on arching the upper part of the chest. Hold this position for six seconds. This exercise is excellent for people who have a tendency to slump, because it stretches the muscles of the anterior shoulders and chest.

4. **Alternate Toe Touch**—Stand with the feet astride, bend from the waist, and touch the right hand to the left toe. Come to the erect standing position before touching the left hand to the right toe. Continue the exercise, alternating sides. Alternate toe touching is an excellent general warm-up exercise; it stretches the muscles of the shoulders, back, buttocks, and legs.

5. **Waist Bend**—Stand with the feet astride and the hands on the hips. Bend forward, head up, and try to attain a position whereby the upper part of the body is parallel to the floor. This exercise is excellent for stretching the muscles of the lower back, upper back, and neck.

6. **Overhead Toe Touch**—Lie on the back and raise the feet straight in the air, supporting the hips with the hands. Point the toes and touch first one foot, then the other, to the floor above the head. Excellent for flexibility of the hip joint, upper back, and neck muscles.

7. **Upper-Back Stretch**—Stand erect, with the feet two to three inches apart, the hands in front, and the elbows raised to the side. While keeping the head up, pull the elbows back. Hold this position for six seconds. Excellent for stretching the anterior shoulder muscles. A good exercise for people with round upper back.

8. **Spinal Stretch**—Place the hands and knees on the floor and hunch the back. Bend the elbows, come slightly forward, and lower the chest toward floor; return to original position. This exercise will develop flexibility of the spinal column.

III. Cardiovascular Endurance Exercises

1. **Jumping Jack**—Stand with the feet together and the hands at the sides. Jump to spread the feet and clap the hands overhead; jump back to the starting position and bring the hands to the sides. Perform the exercise in a rhythmic manner.

2. **Squat Thrust**—From an erect standing position, drop to a squat on the floor and place the hands about shoulder width apart in front of the feet; extend the legs back to assume a front-lean-

ing-rest position; return to the squat position and then to the standing position. The exercise is executed in four counts: down on one; extend on two; return on three; stand on four. Perform the exercise in a rhythmic manner and come to the erect standing position each time.

3. **Hopping**—Stand on the left foot, hands on hips. Hop eight times on the left foot and eight on the right, four on the left and four on the right, two on the left and two on the right, and finally once on each. The bout may be repeated, depending on individual condition.

4. **Forward Scissors**—Stand with hands on hips and the left foot forward. Jump in the air and change foot positions by scissoring the legs. Perform the exercise in a rhythmic manner at least ten times.

5. **Jump Rope**—Skip for 30 seconds, rest for 15; gradually increase the intensity by jumping more rapidly and increase duration by increasing the number of bouts. Start with four half minute bouts and gradually increase as fitness improves.

6. **Running**—Work gradually through use of interval training; little league age boys can do sufficient running to significantly increase their cardiovascular efficiency. A minimum of one mile run should be part of their fitness session.

Benefits From Program

What benefits may you expect from a program of vigorous physical activity?

In an eight-week program at Emory University in 1968 a group of 18 10-year-olds cut 10 seconds off their time in the 600-yard run. A group of 12-year-olds cut off 11 seconds in the 600-yard run. In a trunk flexion test a group of 8-year-olds increased their trunk flexibility 1.6 inches; 10-year-olds, 2 inches and 12-year-olds, 3.3 inches. For the back extension tests, 18 eight-year-olds increased their scores on an average of 3.8 inches; 10-year-olds, 1.6 inches and 12-year-olds, 1.8 inches. In vital capacity tests, eight-year-olds increased 78 cubic centimeters; 10-year-olds, 17 cubic centimeters, and 12-year-olds, 43 cubic centimeters.

Now, we administer quite a number of tests in our Annual Summer Sports Fitness Camp and time does not permit me to go through them all, but suffice to say that over-all improvement is quite noticeable in many other areas.

Similar Program

In a similar type camp at the University of Illinois, Dr. Thomas K. Cureton, well known physical fitness expert, found a steady improvement in ability from six to 14 years of age in an 18-item Motor Fitness Test. His strength graphs followed a similar

ACTIVITY / Partin

trend with a clear acceleration in strength from 11 to 12 years of age upward. This seems to begin at the onset of prepubertal growth and continues well into postadolescence. All track and field events dominated by strength and power follow this same trend. (For example, the 60 yd. dash, running broad jump, running high jump, standing broad jump, shot put, and 600 yard run.)

The vertical jump (explosive power) improves steadily paralleling physical growth. The five minute step test (based on sum of recovery pulse rates 1 to 1½ minutes, 2 to 2½ and 3 to 3½ minutes after exercise) shows a steady improvement from 176 at seven years of age to 162 at 11 years of age.

Past Programs

In regards to adipose tissue and training in a 1955 program at Illinois that was skill-centered, the mean increase in total fat was 28.6 mm. In 1956 with the introduction of repeat 600 yard runs and muscular endurance items, the pre- and post-training sums of total fat were 121.1 and 121.3 mm. respectively. Furthermore, 15 subjects, with 30 more minutes of additional endurance training, showed a mean decrease of 9.3 mm.

As far as cardiovascular work is concerned, Dr. Cureton notes:

1. Several weeks are needed for training boys to adjust to a fairly vigorous program.

2. Every endurance drill should be accompanied by definite effort to breathe well, and deep breathing should be stressed following every work performance.

3. Motivation to "standards" is constantly needed, including participation and demonstration by the instructors.

4. Overeating should be avoided.

5. Some competition is needed, including competition with relative grades or scores in the endurance tables and in the cardiovascular tests. That is, competition against one's own score.

6. The best events to develop circulatory-respiratory endurance so far known include (a) steeplechase running, (b) continuous muscular endurance exercises done for 30 minutes without stopping, (c) interval training in track, running, cycling, swimming, skating, rowing, and taking tests in endurance runs (300-yard shuttle run, 300/60-yard drop-off ratio, 600-yard run on the treadmill and track, cross-country running and treadmill and track, cross-country running and circuit training).

7. Endurance will steadily improve over several months or several years but it usually will not

improve in connection with skill-centered games and sport instruction.

8. Temporary setbacks may be expected if the program is too hard at first. Great care is needed to graduate the program and to provide regular alternation of work with rest intervals, along with great emphasis on deep breathing to aid the circulation and to train the respiratory muscles. The ventilatory volume in work is relatively very great for top endurance athletes.

9. Relatively more sleep is needed with the practice of endurance programs.

In conclusion, I think you can see that vigorous physical activity does indeed benefit young boys and I would exhort you to make a place for physical fitness activities in your program.

Emory University, 30322

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SECOND ANNUAL BIRTH DEFECTS SYMPOSIUM

"Disorders of Glucose Metabolism in Children," the second annual Birth Defects Symposium, will be October 30-31, 1970, at the University of Florida College of Medicine, Gainesville, Florida. Sponsored by the university's Institutional Division of Endocrinology and Metabolism and the National Foundation March of Dimes Birth Defects Center, the symposium will feature discussions of diabetes mellitus, hypoglycemia of childhood and energy metabolism, as well as case presentations. Guest faculty are Allan Drash, M.D., Associate Professor of Pediatrics, University of Pittsburgh, and Donough O'Brien, M.D., Professor of Pediatrics, University of Colorado.

The relation between dietary intake and blood lipids is discussed by an authority in the field.

Special Article

A Practical, Palatable and Prudent Way of Eating

ANCEL KEYS, Ph.D.,* *Minneapolis, Minn.*

IN DEVISING A DIET in the hope of reducing the risk of coronary heart disease, attention may be paid to data from six main sources or varieties of evidence. There are data from dietary experiments on animals; on personal characteristics of people found to predispose to the disease in prospective studies; data from experiments on man on the effects of the diet on blood lipids, particularly on serum cholesterol; data from dietary trials directed at either primary or secondary prevention; information from epidemiological studies of populations on contrasting modes of life.

Dietary experiments on animals have been immensely important in showing that the disease can be produced by dietary means, but their teaching in regard to a good diet for man really amounts only to two points. First, if man is metabolically similar to a rabbit or a chicken, his long-time diet should provide no more than about half a gram of exogenous cholesterol per thousand calories. Of course, if he is metabolically more like a rat or a dog, his dietary cholesterol intake might be allowed to be perhaps five or 10 times that. Since the average American diet provides considerably less than half a gram of cholesterol per thousand calories, the wisdom gained from the animal experiments on this point is not very helpful.

The second conclusion from dietary experiments on animals is that it would seem unwise to continue indefinitely on a diet providing more than half the calories from butterfat or coconut oil. Clearly we must turn to other sources of information to get practical advice about a desirable diet for man.

Diet and Disease

Characteristics found to be associated with in-

creased incidence of coronary heart disease indirectly point to the diet on two counts. Firstly, they show some increased risk associated with obesity largely, it seems, because of associated hypertension which often goes along with the obesity. But, in any case, it would seem wise to restrict calories to control obesity. More consequential, of course, is the fact that the serum cholesterol concentration is an extremely important risk factor for coronary heart disease. Hence attention is directed to the diet because the influence of the diet on the serum cholesterol level is now well established.

In a given population group, differences in serum cholesterol concentration between individuals are seldom explained by dietary differences. At least it is true that surveys of the diet in a well-defined population sample generally fail to show a close correlation between individual cholesterol levels and such items as the amount of fat or of cholesterol itself in the diets they report themselves to be eating. The situation is similar to the relationship between calorie intake and obesity. Dietary surveys generally fail to find a close correlation between dietary calories and relative obesity of individuals in a group. But no one, since Dr. Herman Taller, concludes that "calories don't count."

Cholesterol and Diet

Controlled dietary experiments on man have provided the primary data on how to alter the serum cholesterol concentration by controlling the diet. In regard to fatty acids, the main features are readily summarized. After much fumbling, misunderstanding and argument, the results from all carefully designed and well-controlled experiments are remarkably consistent.

In the human diet, linoleic and other poly-unsaturated fatty acids depress the serum cholesterol level while lauric, myristic and palmitic acids have a cho-

* Director, Laboratory of Physiological Hygiene, School of Public Health, University of Minnesota.
Presented at the Georgia Symposium on Prevention in Cardiology, Atlanta, Ga., May 28-29, 1969.

lesterol-raising effect, an effect that, gram for gram, is about twice as powerful as the opposite effect of linoleic acid. Oleic acid and other mono-enes, as well as saturated fatty acids with fewer than 12 or more than 17 carbon atoms, can be considered neutral; the serum cholesterol concentration is not significantly altered when they are exchanged isocalorically for starch in the diet.

Good agreement between observation and prediction is shown in 99 sets of experiments, six to 25 men in each set of experiments, each person being his own control, on prisoners and mental patients studied under metabolic ward conditions at Harvard and at Minnesota. There is similar agreement in data from dietary experiments on man elsewhere, including studies in Sweden and Finland. Empirically, a good deal is known about the effects of fatty acids. Though there are still questions about the mechanisms involved, we do know what to expect when we change the diet or when we analyze the diet of the population.

When cholesterol is added to a cholesterol-free human diet, on the average there is some response in the serum level. The relationship of cholesterol serum level in man to the amount of cholesterol taken in the diet is a logarithmic one and the effect is very small except with diets that are practically cholesterol-free. The general range of ordinary American diets is something like 150 to 400 milligrams of cholesterol per thousand calories. Changes in cholesterol intake over that range produce only very small changes in the serum. Here, too, the results are consistent in different laboratories as shown in analysis of reports from five independent studies. So it is now known what to expect from altering the fatty acids and cholesterol in the diet.

Study of Nutrients

Besides the lipids other nutrients in the diet have been studied with care. Over the range of tolerable variation in human diets, differences in the intake of vitamins, minerals and proteins have no significant effect on cholesterol level or cholesterol metabolism. There are, however, some interesting and not yet well understood effects of complex carbohydrates in the diet. Pectin in the diet, for example, has a modest cholesterol-lowering effect. In the diet, some other complex carbohydrates, but not fiber, also have some depressing effect on cholesterol in the serum. Complex carbohydrates in leguminous seeds are apparently responsible for a cholesterol depressing effect observed when such seeds are fed to man in controlled experiments. In populations that eat a lot of beans, chick peas, lentils, and other legumes

this effect may be consequential. In India, in Brazil, in the Caribbean and in parts of the southeast Mediterranean region, the consumption of legumes may explain some of the low incidence of coronary heart disease seen in these areas. In the rural area of the heel of the Italian boot dietary surveys have reported about 2 ounces, some 70 grams, of dried beans in the average daily diet. In that area serum cholesterol is low but most of the credit for that fact belongs to the small amounts of saturated fat in the diet.

Information from such dietary experiments on man, though at an earlier period when relationships were much less well understood than now, was the basis for devising diets used in secondary and, to a more limited extent, primary prevention trials. So far none of the diets used in such prevention trials have taken full advantage of what is now known about the effects of the diet on the blood lipids but substantial cholesterol lowering can be achieved even with inefficient dietary prescription.

Experiments With Diets

Experiments with diets to prevent or control coronary heart disease have been going for many years. This is not the place to enter into detailed debate the results of those trials. However, it should be noted that 14 major dietary experiments on prevention have been reported from different parts of the world and 12 of these have given positive results. Two negative trials have been reported from London, England. One of those negative reports can be dismissed as having too few subjects for too short a time to warrant any hope of showing anything, positive or negative. The other experiment, much better technically, has been widely talked about as being negative. Actually, the results of that trial are favorable to the cholesterol-lowering diet but the significance of that result is only at about the 8 per cent level. There is something of the order of one chance in 12 that such a favorable result would come about by chance.

The last, much neglected but certainly not the least interesting source of guidance in devising anti-coronary diets, is afforded by comparative studies on populations. Recent vital statistics indicate some clues not available to us when we began our own studies in the field 17 years ago. We now have death rates, calculated from data made available recently by the World Health Organization from the seven countries where for the last 10 years we have been carrying out prospective studies and where we still continue our follow-up studies on over 12,000 men. The total, all-causes of death rates and the death rates ascribed to coronary heart disease, show enormous differences for men. The death rates of women are much less different in the several countries. Their

relative uniformity in total all-causes death rate reflects the fact that they have so little coronary heart disease and differ little in this respect. In men, however, death rates ascribed to coronary heart disease are of the order of five or 10 times greater in some populations than in others.

We all have reservations about official vital statistics except in one respect. Modern vital statistics are pretty reliable about telling us how many people there are and whether they are alive or dead. That much we can accept at least. The all-causes death rates of adults in middle life cannot be discounted; and those death rates differ as they should if the coronary death rates were real.

Contrasting Diets

One of the reasons for picking for study the particular populations we did was because we wanted to study people living in contrasting ways in regard to the diet. Getting the dietary information proved to be almost the most expensive and difficult part of the whole operation.

The dietary studies produced dietary data, on individual men selected at random, from seven-day food weighings with chemical analysis of the week's food composites. Those dietary surveys were repeated at various times of the year to cover seasonal variation.

In four cohorts the average diets proved to be very high in saturated fatty acids—U.S. railroad men, men in East and West Finland, and men in Zutphen, a town in central Holland. East Finland definitely has the diet highest in saturated fatty acids. Except for our two cohorts of men on the island of Kyushu, Japan, none of the diets is really low in total fats. The diets in Crete, Corfu and Dalmatia proved to be relatively high in total fat but low in saturated fatty acids, reflecting the abundant use of olive oil in those diets. None of the diets was higher in polyunsaturated fatty acids than the U.S. average. Around 8 per cent of calories from polyunsaturates is the highest so far found in the diet of any population in the world. That fact makes one wonder when we hear of some enthusiasts who would like to prescribe, for indefinitely prolonged use, diets providing 15 per cent of calories from linoleic acid.

Age Differences

Age-standardized prevalence rates of coronary heart disease differed greatly in these population samples. Diagnosis was made primarily on the Minnesota code applied to the 12-lead ECG in rest and, unless contra-indicated, at the end of a three-minute standard exercise test. The confidence limits on these rates are fairly wide but there is no doubt that the U.S. men and the men of East Finland are not re-

motely like the men of the Greek islands of Crete and Corfu or in Dalmatia in respect to coronary heart disease. From theories about the effects of fats in the diet and cholesterol in the blood serum the general trend of these data is not surprising but the magnitude of the differences is unexpected. Still, the determined critic could suggest that these differences might reflect differences in lethality of the disease, perhaps better medical care in the U.S. and in Finland producing better survival after a heart attack and hence higher prevalence.

The incidence figures reported here are not final; they are *not* for publication as yet. Five-year follow-up examinations have been completed for all cohorts but the analysis of the data is still in progress and the figures are subject to minor correction. But there is no doubt that there is a very high correlation between the rates of incidence and prevalence in these populations. But such far-fetched suggestions are disproved by the actual incidence observed in the population samples. The Americans and the East Finns are very high in both prevalence and incidence of coronary heart disease. Though similar in this respect, the Finns and the Americans are strikingly different in other ways, the Finns thin and physically very active, the Americans fat and physically indolent. Median serum cholesterol values were 265 in East Finland, 235 in the Americans, a difference corresponding with their dietary difference, only more so: that is to say, a serum cholesterol difference somewhat greater than we should expect from the dietary differences judging from the results of short-time dietary experiments.

Other Extreme

At the other extreme in regard to the burden of coronary heart disease are the men of Corfu, Dalmatia and Crete—men who are closely similar to the East Finns in relative body weight, body fatness and smoking habits and rather similar in physical activity. Compared with the Finns, a larger proportion of these Greeks and Yugoslavs are sedentary, but the majority of the men are more active than the average men of the same age in the United States. For the Americans and the Finns the five-year coronary rates, age-standardized, were 659 and 800, respectively, compared with a rate of only 119, with a standard error of 25, for the men of Crete, Corfu and Dalmatia. Moreover, there is also a great difference in the total all-causes death rates, the death rate of the men in Crete, Corfu and Dalmatia combined being less than half that of the Americans, less than a third that of the Finns. So it cannot be proposed that coronary deaths are missed in Greece and Dalmatia and ascribed to other causes. It is not insisted that these striking differences in mortality are

simply due to the differences in the diets. But it is obvious that the diets of the men in Crete, Corfu and Dalmatia can hardly be considered to be unhealthy.

It is instructive to compare the nutrient composition of the diets of these cohorts of men. Protein as percentage of calories in Crete and Corfu is a little lower than the average for U.S. men, while Dalmatia is somewhat above the U.S. average in protein calories, partly because the study area in Dalmatia is a 40-mile strip along the Adriatic coast where fish is an important part of the diet. Alcohol, mostly in wine, makes an appreciable contribution to calories in Greece and especially in Dalmatia where 20 per cent of calories from alcohol is the average for the men in our cohort. This may seem alarmingly high but the average for a considerable number of American businessmen and military personnel is higher. A quart of light table wine, 12 per cent alcohol by volume, provides about 675 calories; at 3,000 total calories, a quart of wine a day would amount to 22.5 per cent of total calories. The diets in Greece and Dalmatia are not low-fat diets. On the average, fats provide 33 per cent of total calories in Corfu and Dalmatia, 40 per cent in Crete. The average U.S. white man's diet is about 40 per cent fat calories.

In terms of food items, cereals (almost all as wheat bread) and olive oil dominate the dietary picture in Greece and Dalmatia. In other areas of the world where coronary heart disease is relatively uncommon, the picture is similar in regard to the importance of cereals. The kind of cereal may differ, however, being rice in the Orient and corn (maize) in parts of Africa and Latin America.

Sucrose and Disease

Sugar is trivial in the diets in rural Greece and Dalmatia compared with the United States, or even with Finland where the per capita sugar intake is much smaller than that in the United States. But the low intake of sugar in these areas with so little coronary heart disease should not be taken as support for Dr. John Yudkin's claims about sucrose being the major dietary poison of our times. It should be noted that the per capita intake of sucrose in England is much higher than that in the United States but the Americans have much more coronary heart disease. The sucrose intake in Finland is only half that in Sweden but the death rate from coronary heart disease in Finland is twice that in Sweden. The Greek and Dalmatian diets provide an abundance of fresh vegetables and of fresh or dried fruits throughout the year, but the outstanding common feature of the Greek and Dalmatian diets is the low content of saturated fatty acids.

The breakdown of fats in the diets of these populations that differ so much in disease is instructive. As noted earlier, the diets of Greece and Dalmatia are not high in poly-unsaturated fatty acids; their peculiarity is that they are low, by American standards, in saturates. In those diets saturated fatty acids are less than half, as percentage of calories, the current average in American diets.

From consideration of all of the evidence it is not hard to devise a diet that is practical and prudent. And, as my book, *Eat Well and Stay Well*, will prove, such a diet can be delightfully varied and palatable. Such a diet is not guaranteed to save your life but at least you can be in good company with populations that have low total death rates as well as relatively low incidence of coronary heart disease. A diet low in calorie density is advisable, especially if overweight is a problem, because such a diet provides the satisfaction of feeling full without too many calories. The diet should be low in saturated fatty acids but not necessarily very low in total fats; vegetable oils, except coconut and palm oil, can be used liberally to provide the flavor and cooking properties that most people like. Nothing is totally *forbidden* in the sensible diet. If you like cheese, the advice is simply, "don't go overboard." Highly flavored cheeses are suggested for the cheese addict because a little will go a long way. Cholesterol watchers are advised to stay away from ice cream but if no ice cream at all seems too Spartan, small portions at infrequent intervals may be allowed. Fortunately, it is now clear that chocolate does not increase the serum cholesterol level and therefore is no longer on the dietary blacklist. Chocolate is high in saturated fatty acid but almost all of it is stearic acid which does not have the cholesterol-promoting effect of the real villains in this picture—lauric, myristic and palmitic acids.

Food Industry Cooperation

Food industry in general is responding to the new knowledge about the undesirability of diets rich in saturated fatty acids. The new "tub" or soft margarines are generally far better in regard to blood cholesterol effect than either butter or the old-fashioned hard margarines. The dairy industry is developing and promoting low-fat dairy products. The meat industry is providing much leaner meats. But not all new developments in food industry are good.

Recently our grocery shops have been flooded with a great many substitutions for cream and whipped cream, but so far we have not found one that can be recommended to anyone interested in blood lipid control or a diet to minimize the risk of developing coronary heart disease. In the April, 1969, issue of the *American Journal of Clinical Nu-*

trition, Dr. E. Monsen published analytical data on 14 of these cream substitutes. Almost all of them appear to have been loaded with coconut oil—the worst fat for the cholesterol watcher—but in any case it is clear that all of them have more cholesterol-promoting power than the butterfat they would supplant.

Cream substitutes of far more acceptable composition would not be difficult to make nor would they necessarily be expensive. The real problem is shelf life. Coconut oil is favored by the manufacturers because it keeps a long time for the simple reason that it is almost completely saturated. Until American

food distributing and selling systems are willing to cope with the problem of giving the public fresh food rather than simply food that will not spoil or deteriorate further for a long time, we shall be plagued with shoddy imitations that may add new health hazards. Useful change in the diet will come from the food industry responding to the pressure of physicians, medical scientists, dietitians and the interested and educated public. Our U.S. Public Health Service should provide reinforcement with proper educational materials.

University of Minnesota

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL JULY 26, 1970

Finance: Approved an appropriate annual audit of GRMP accounts. Approved an additional \$25 for the School Child Health Committee, \$710 for Campus equipment, and \$300 expense advances to each GRMP Field Representative. Referred to Council requests for an additional \$3,050 for the Committee on Annual Session speaker expenses, and \$300 for the Mental Health Committee Drug Abuse Essay Contest Prizes. Also directed the Executive Director to prepare a policy statement on Committee budget management for consideration by Council, and directed the Secretary to advise the Woman's Auxiliary that they will be expected to submit an annual budget request of projected expenditures to be paid by MAG.

Appointments:

Committees on Legislation and Quackery: Edward Leader, M.D., Atlanta.

Advisory Committee on Woman's Auxiliary: Luther J. Smith III, M.D., Columbus.

Advisory Committee to Ga. State Assn. of Medical Assistants: Robert B. Quattlebaum, M.D., Valdosta.

Board of Trustees for Pre-School Screening of Vision and Hearing: Fred L. Allman, M.D., Atlanta; Irving D. Hellenga, M.D., Toccoa; Fleetwood Maddox, M.D., Macon; S. William Clark, M.D., Way-

cross; Martin Majoros, M.D., Atlanta, Warren Griffin, M.D., Macon; Barrie H. Thrasher, M.D., Atlanta, Robert O. Thomas, M.D., Augusta; and John Turner, M.D., Atlanta.

Accepted with regret the resignation of George H. Alexander, M.D., Forsyth, as Coordinator of the Georgia Regional Medical Program.

Comprehensive Health Care: Referred to the Committee on Insurance and Economics a resolution from Columbus Blue Shield calling for a study toward establishing a Comprehensive Health Care Insurance Plan for Georgia.

New Members: Directed the Staff to include additional materials in new member kits, send monthly new member lists to Councilors for follow up, and arrange a portion of the 1971 County Society Officers' Conference for new members, all designed to aid in new member indoctrination.

Medical College of Georgia: Received for information was a report on new activities at MCG, presented by Dean Christopher Fordham, M.D. This report will also be presented to the Council at its September meeting.

Next Meeting: 2:30 p.m., Sunday, August 16, 1970, Atlanta Marriott.

POSTGRADUATE COURSE IN LARYNGOLOGY AND BRONCHESOPHAGOLOGY

The Department of Otolaryngology of the University of Illinois at the Medical Center will conduct a postgraduate course in Laryngology and Bronchoesophagology from November 2 through 13, 1970. This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the Eye and Ear Infirmary of the University of Illinois Hospital, 1855 W. Taylor St., Chicago, and will include visits to a number of other Chicago hospitals.

Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures and several motion pictures.

Interested registrants will please write directly to the Department of Otolaryngology, Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Medical College of Georgia

Medical Grand Rounds

ACUTE INTERMITTENT PORPHYRIA

ALBERT A. CARR, M.D.,*

and J. LARRY SANDERS, M.D.,† Augusta

ALBERT A. CARR, M.D.: The clinical findings of the young woman in this discussion are consistent with the diagnosis of an uncommon disease, acute intermittent porphyria. She died from the disorder which illustrates the fact it may not be a benign disease. It is important for us as clinicians to refresh our knowledge of this disease since it can mimic so many clinical conditions such as psychiatric disorders, acute organic brain syndrome, hyperthyroidism, hypertension—especially pheochromocytoma, peripheral neuropathy from minimal to Guillain-Barré-type, autonomic nervous system neuropathy, diabetes mellitus, acute surgical abdomen, and hypersecretion of antidiuretic hormone. In addition there are many medications which will cause exacerbations of the clinical manifestations and may cause death. This is a genetically transmitted autosomal dominant disease of unknown cause with abnormalities in liver porphyrin metabolism. Females are involved more than males. Most of the clinical manifestations can be explained by lesions in various areas of the nervous system. However, a cause and effect relationship between the altered porphyrin metabolism and the clinical manifestations has not been established. That is, the various products of porphyrin metabolism which are elevated in tissues and are excreted in abnormal quantities in the urine and feces do not cause the clinical manifestations. It is similar to problems in diabetes mellitus where many abnormalities in carbohydrate and lipid metabolism have been described, yet the exact reason for the lethal abnormalities in the basement membrane is unknown. It is obvious since the exact causes of the nervous system lesions are unknown the treatment is mostly supportive and involved in avoiding drugs which cause exacerbations.

Patient History

J. LARRY SANDERS, M.D.: This was the first Eu-

gene Talmadge Memorial Hospital admission for this 19-year-old Negro woman from Dawson, Georgia, who had been employed in a local shirt factory prior to her illness. The patient had been in good health until the first week of September, 1969, when she developed abdominal pains with nausea and vomiting immediately after her regular menses. She saw her local physician the following week for these complaints and increasing generalized muscle weakness. During the following six days she received Penicillin, Tao®, Percodan®, Leritine® and Thorazine®. All therapy was discontinued September 20, 1969. The weakness continued to progress and the patient was hospitalized in Albany, Georgia on 10/9/69. Chief complaints on that hospitalization were weakness, vague headaches, nervousness, episodes of sweating and red urine. Pertinent findings on physical examination were a blood pressure of 160/110 mm of Hg with questionable exophthalmos and persistent tachycardia. The serum Na was 124 mEq/L. The serum SGOT, alkaline phosphatase and cholesterol were elevated. Thyroid function studies were: T₃ uptake of 30.2 per cent and a 24-hour RAI uptake of 20 per cent. A regitine test was positive. Upper gastrointestinal series, barium enema, chest, and intravenous pyelogram x-rays were all normal. The urinalysis was positive for glucose. Medications given on this admission included Nembutal®, Aldomet® and Tapazole®.

She was discharged not improved to be referred to Eugene Talmadge Memorial Hospital for probable acute glomerulonephritis with secondary hypertension or possible pheochromocytoma. While awaiting this admission she progressively became much weaker to the point of being unable to walk and care for her daily needs. She was readmitted to the Albany Hospital. The blood pressure on this admission was 160/120 mm of Hg. The hospital course was complicated by convulsions and extreme constipation. Medications received were Dilantin®, Sodium Amytal®, Reserpine, Penicillin-G, Apresoline® and Thorazine®. A consulting physician suggested the diagnosis of acute intermittent porphyria which was

* Associate Professor of Medicine, Director, Clinical Investigation Unit, Section of Clinical Endocrinology and Metabolism, Department of Medicine, Medical College of Georgia.

† Intern, Department of Medicine, Medical College of Georgia.

confirmed when porphobilinogen in high amounts was found in the urine. There was no family history of "porphyrinuria."

She was transferred to Eugene Talmadge Memorial Hospital on 11/12/69 for supportive care. She was an emaciated Negro female who was able to speak only in a whisper and was so extremely weak she could not move her arms or legs, being only able to wiggle her fingers and toes. She was alert and well oriented. The blood pressure was 120/80 in both arms and 140/80 mm of Hg in both legs with a regular pulse of 120 per minute. The body temperature was 37°C. She had prominent exophthalmos and was able to close her eyes on command. The thyroid gland was not enlarged. Rales were not heard on auscultation of the chest. By percussion there was paralysis of the right hemidiaphragm. There was marked scoliosis of the thoracic spine. A Grade III/VI short, harsh ejection type systolic heart murmur was heard with maximal intensity over the left sternal border at the 3rd intercostal space. The PMI was in the 5th intercostal space in the left midclavicular line. There was bilateral costovertebral angle tenderness. The liver and spleen were not enlarged. Masses consistent with feces were felt in the left lower abdomen up to the splenic flexure area and rectal examination confirmed a fecal impaction. After enemas the masses were no longer palpated. Genitalia were within normal limits. She was oriented to time, place and person. There were no deep tendon reflexes except for a minimally active wrist jerk. There was no Babinski sign. There was almost complete motor paralysis of the extremities with no sensory losses.

Hematocrit was 31 per cent. A white count was 13,000 per cu mm with a normal differential. A urinalysis was normal with specific gravity of 1.018. The serum sodium was 130 mEq/L with the serum creatinine 1.0 mg per cent. Urine uroporphyrins and coproporphyrins were markedly elevated at 6.776 and 0.79 mg/24 hrs (upper limits of normal .026 and .16 mg/24 hrs). The serum PBI and total thyroxine (T_4) were 9.3 and 7.3 μ g per cent respectively (upper limits of normal 8.0 and 6.0 μ g per cent respectively) and the serum cholesterol was elevated at 291 mg per cent. The serum albumin was 2.6 gm per cent and globulins 3.1 gm per cent. Fasting plasma glucose was 115 and 107 mg per cent on two different occasions. A serum uric acid was 7.6 mg per cent. Her hospital course was complicated by respiratory failure which required tracheostomy and mechanical assistance. She also had findings of acute organic brain syndrome with convulsive seizures for which she was given Dilantin® and Valium®. She was unable to eat and was fed by nasogastric tube and received intravenous fluids. She re-

mained hyponatremic during the hospitalization. On the fourteenth hospital day tarry stools were found and she required blood transfusions for gastrointestinal bleeding, the site unknown. She received Keflin® for fever and a urinary tract infection; on the fifteenth hospital day she was given Furadantin® for the urinary tract infection. The next day she became unresponsive with severe bradycardia and hypotension. Resuscitative measures failed and she died that day.

Clinical Findings

ALBERT A. CARR, M.D.: Several findings during the clinical course of this patient need to be emphasized. There was intermittent arterial hypertension and a positive regitine test. She complained of nervousness, episodes of sweating and tachycardia. These led her physicians to think of the diagnosis of pheochromocytoma. The marked variations in blood pressure, nervousness, sweating and abdominal pain were probably due to autonomic nervous system neuropathy which is a common occurrence in acute intermittent porphyria. She also had findings compatible with hyperthyroidism; nervousness, weakness, sweating, tachycardia, exophthalmos, elevated serum PBI and serum thyroxine by column (T_4). In fact she was treated with Tapazole® at one time. However, her thyroid was not enlarged, the serum cholesterol was elevated and the 24 hour radioactive iodine uptake (RAI) was normal. Elevated serum PBI and T_4 have been described as due to increased serum thyroid binding globulin in this disease. The RAI uptake is normal; the serum cholesterol elevated, the thyroid normal in size and when measured the basal metabolic rate normal in acute intermittent porphyria, all of which exclude the diagnosis of hyperthyroidism.

The hyponatremia this patient had consistently throughout her hospital course, with normal renal excretory function as judged by a normal serum creatinine, was most likely due to hypersecretion of antidiuretic hormone (ADH). Hypersecretion of ADH in acute intermittent porphyria has been shown by others to be the result of lesions in the supraoptic and paraventricular nuclei areas of the hypothalamus. The syndrome produced by excessive inappropriate secretion of ADH results in expansion of extracellular fluid volume, renal sodium wasting, and hyponatremia. The hyponatremia is best corrected by water restriction rather than the administration of sodium. The syndrome of inappropriate secretion of antidiuretic hormone may occur with a variety of other clinical disorders such as carcinoma, renal and heart failure.

The peripheral neurological deficit this young woman had was severe and was much like the as-

cending paralysis of the peripheral neuropathy—the Gullian-Barré syndrome. It was severe enough to cause maximal motor paralysis to the point of requiring respiratory assistance. Neuropathy is a common manifestation of acute intermittent porphyria and other causes of neuropathy such as lead toxicity, diabetes mellitus or alcohol have to be excluded. Of interest is the fact that the spinal fluid protein is normal in association with the neuropathy of acute intermittent porphyria.

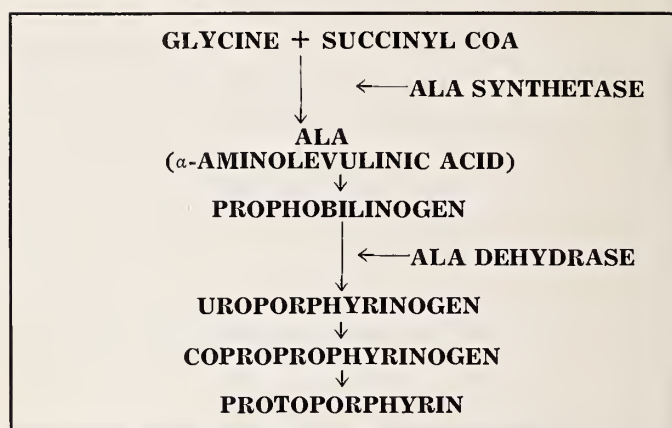
Differential Diagnosis Problem

The convulsions, confusion, and agitation in the clinical course of this patient most likely represented central nervous system involvement which occurs in this disease and presents a problem of differential diagnosis also. This patient also had hyperglycemia which presented the diagnostic and practical problem of the exclusion of diabetes mellitus. Elevated fasting plasma glucose and impaired glucose tolerance with impaired or delayed insulin secretion occurs in acute intermittent porphyria. The patients presumably do not have diabetes mellitus since they do not develop any of the usual diabetic complications and do not require insulin therapy. The reason for the abnormality in glucose tolerance and impaired insulin secretion is unclear.

In summary this young woman with acute intermittent porphyria during the course of her illness had symptoms and signs consistent with or required exclusion of: 1) acute organic brain syndrome, 2) peripheral and autonomic nervous system neuropathy, 3) pheochromocytoma, 4) hyperthyroidism, 5) diabetes mellitus, 6) acute surgical abdomen and 7) hypersecretion of antidiuretic hormone.

The clinical manifestations presented by this patient demonstrate the protean nature of the disorder. Therefore, one has to rely on chemical tests to confirm the diagnosis of acute intermittent porphyria. It is well recognized that in the disease there is an overproduction of the porphyrins and porphyrin precursors with increased liver concentrations of α -aminolevulinic acid synthetase. Figure 1 demonstrates the abnormality. The result is the increased excretion in the urine of 1) α -aminolevulinic acid (ALA), 2) porphobilinogen, 3) uroporphyrins, and 4) coproporphyrins. The easiest and most readily available chemical test is that for porphobilinogen in the urine. This is a screening or spot test for abnormal amounts of urinary porphobilinogen and in the greatest majority of patients with acute intermittent porphyria will establish the diagnosis. It is obvious that quantitative determinations of either α -aminolevulinic acid or porphobilinogen are more

FIGURE 1
Porphyrin Biosynthetic Pathway



sensitive tests when accurate normal controls are available. However, these are more difficult to perform and more time consuming. The Watson-Schwartz test is used for determination of porphobilinogen and is named after those investigators who developed and evaluated its usefulness. Porphobilinogen, which is colorless, will give a red-brownish color on reaction with Ehrlich's aldehyde reagent. The porphobilinogen-aldehyde complex is insoluble in chloroform and butanol and these properties are utilized to separate it from other color complexes which may give false positive reactions. Porphobilinogen in concentrations of 3-6 mg/L are required for color to develop.

Test for Porphobilinogen

Thus, the volume of urine in relation to the excretion rate of porphobilinogen is important. Ideally, maximally concentrated urine should be used for the test. There are some false positives which are caused by pyridium, methyl red, skatol red and some melanin products. The color complexes which are insoluble in chloroform can be differentiated by the use of 22 per cent hydrochloric acid as a control. If color develops on adding 22 per cent hydrochloric acid to the urine this indicates a contaminant. There are also factors which will inhibit the color development in urine such as indicans, indoles, 5-hydroxyindole acetic acid (5-HIAA) and a yet uncharacterized inhibition which increases in magnitude with time. Indicans will give a yellow color in the chloroform layer of the initial extraction. If inhibitors are present various column resin techniques will be required to separate the inhibitors in order to quantitate the porphobilinogen. Figure 2 is representative of a positive urine spot test for porphobilinogen. The test proceeds from left to right. The patient's urine, JJ, with acute intermittent porphyria is always paired with normal urine, C, for each part of the test. Urine with large amounts of porphobilinogen at alkaline pH will

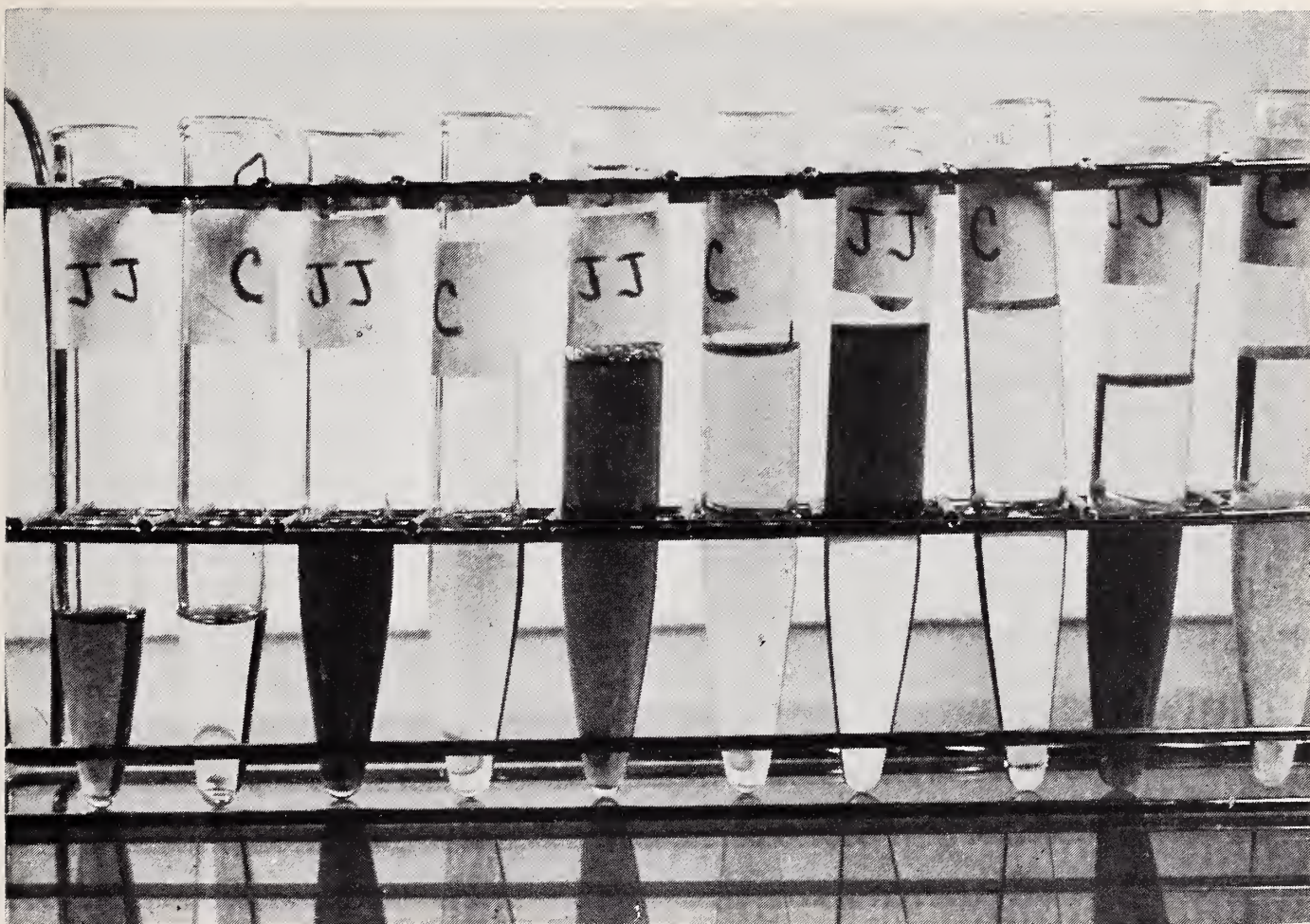


FIGURE 2
Urine Porphobilinogen Spot Test (Watson-Schwartz Spot Test).

turn brown after exposure to air. This is due to conversion of porphobilinogen to a non-porphyrin which is brown, porphobilin. This is demonstrated by tube JJ at the extreme left. Three ml of fresh concentrated urine are added to an equal volume of Ehrlich's aldehyde reagent (0.8 gm p-dimethylaminobenzaldehyde, 150 ml concentrated hydrochloric acid and 100 ml distilled water). As demonstrated in pair of tubes second from the left the porphobilinogen-aldehyde complex is red-violet-brownish in color in tube JJ whereas the adjacent normal urine-Ehrlich's aldehyde reagent mixture, C, is yellowish in color. As shown in the next pair of tubes to the right, an equal volume of saturated sodium acetate (6 ml) is added and mixed. The same colors prevail but are more diluted. This mixture is extracted four times with five ml of chloroform which removes the chloroform soluble color complexes, such as the urobilinogen-aldehyde complex. The chloroform layers to the bottom and the aqueous-porphobilinogen-aldehyde complex remains on top. This is demonstrated by the pair of tubes second from the extreme right. Note there is a faint yellowish color in the top layer for the normal urine, C. The top aqueous-porphobilinogen-aldehyde complex layer is extracted with one-half volume butanol.

The porphobilinogen-aldehyde complex remains at the bottom while non-specific colors remain in the top butanol layer. The pair of the tubes at the extreme right show the positive test for porphobilinogen in tube JJ in the bottom layer and no color or only slightly cloudy fluid in the bottom layer of the normal urine, C. The Ehrlich's aldehyde reagent should be colorless or only a light yellow and should be kept in a dark bottle. If it is brown or brownish red it should not be used and fresh reagent made. It is important to use fresh urine for the test so that inhibitors of the porphobilinogen-aldehyde complex are not allowed to develop and so a significant amount of porphobilinogen is not converted to the brown porphobilin. Lead poisoning may cause clinical symptoms and signs of acute intermittent porphyria and there may be a positive urine test for porphobilinogen. However, it is differentiated by extremely high urine levels of coproporphyrins and high urine and serum lead. Variegate porphyria is different in that the urine test for porphobilinogen is usually negative during remission and there may be skin involvement. In addition there are differences in uroporphyrin, coproporphyrin and protoporphyrin excretion patterns in the urine and feces. In general, the urine porphobilino-

gen test is positive during remissions of the clinical manifestations for acute intermittent porphyria.

Reason for Lesions Unknown

The clinical symptoms and signs are due to nervous system lesions of demyelination and axon degeneration. The precursors of the porphyrins and porphyrins do not cause the lesions or symptoms. The exact reason for the lesions is unknown. There is speculation that a defect(s) in oxidation at a mitochondrial level causes defective energy metabolism and thus the nervous system lesions. The altered energy metabolism may secondarily stimulate porphyrinogenesis by induction of the enzyme α -aminolevulinic acid synthetase and by making more succinyl coA available. The overall effect of defective oxidation can reduce high energy phosphorylated compounds like adenosine triphosphate (ATP), increase glycolysis, increase lipogenesis, and cause changes in dicarboxylic acid metabolism, all of which can be associated with increased porphyrin synthesis. These speculations are based on measurements of α -aminolevulinic acid synthetase, nicotinamide adenine dinucleotide (NADH), NADH oxidase, adenosine triphosphate (ATP), glycolytic activity, and conversion of pyruvate into succinyl coA *in vivo* and in liver cell tissue cultures. Porphyrinogenesis can be stimulated by drugs. Many of these drugs are known to cause exacerbations of clinical findings in acute intermittent porphyria and fall in the category of barbiturates, anticonvulsants, tranquilizers, and antifungal agents. However, it must be emphasized that it is still speculation as to the cause of the nervous system lesions. Defective oxidation could be an explanation and compensatory biochemical changes may be used to explain the dissociation between clinical findings and porphyrinogenesis. A good readily available measurement of defective oxidation may correlate better. Clinically, however, the important fact is that certain drugs cause exacerbations of the disease. These drugs, in general, impair mitochondrial oxidation, have potent effects on microsomal detoxification systems and are associated with increases in α -aminolevulinic acid synthetase in experimental conditions. These drugs are listed in Table 1.

Management of Patients

The management of the patients is supportive and avoiding the drugs listed in Table 1 which cause exacerbations and possibly death. Infections should be treated quickly and effectively since patients with acute intermittent porphyria may become worse in association with infections. The clinical course can

TABLE 1
DRUGS WHICH CAUSE EXACERBATIONS OF
ACUTE INTERMITTENT PORPHYRIA

Barbiturates	Estrogens
Sulfonal®	Progesterone
Trional®	Methylprylon (Noludar®)
Sulfonamids	Mesantoin®
Sedormid®	Dilantin®
Glutethimid (Doriden®)	Megimide (Bemegride)
Meprobamate	Methasuccimid (Celontin®)
Alcohol	Phensuximid (Milontin®)
Lead	Griseofulvin
Arsenic	Hexachlorobenzene

be unpredictable and some of the patients can make remarkable recoveries if the nervous system lesions are not too extensive. Drugs like Thorazine® help combat restlessness. Demerol® and aspirin have not been shown to make the condition worse. The arterial hypertension is generally intermittent and does not require therapy unless extremely elevated. It is obvious if the patient has sustained hypertension with diastolic blood pressure above 115 mm Hg, therapy is indicated. The hyponatremia, if severe, requires fluid restriction. Minimal depression of the serum sodium is of no harm. Attention must be directed to the fact that constipation and fecal impactions are common. Since the clinical manifestations of acute intermittent porphyria are so protean it is most important to think of the diagnosis early before many of the drugs which can cause exacerbations are used. Therefore, awareness of the disease and frequent use of the urine screening test for porphobilinogen is mandatory. Finally, it should be emphasized that other than avoiding known drugs which cause exacerbations and general support the care of the patients with this disease involves the art rather than the science of medicine.

Medical College of Georgia

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Miescha, P. A. and Jaffé, E. R.: Porphyria and disorders of porphyrin metabolism, *Seminars in Hematology* 5:293-433, 1968.

AMERICAN COLLEGE OF SURGEONS MEETING

The 56th Annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 12-16, 1970. Eighteen postgraduate courses are being offered. Registration fee is \$20 for the 12-hour courses, \$23 if manual is provided; \$10 for the 6-hour courses, and \$15 for the 9-hour course.

For further information, contact Mrs. Sara Barr Cohen, Publicity Director, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

In this study, thioridazine was observed to be a useful agent in the outpatient treatment of various types of mental disorders.

Chemotherapy in Private Psychiatric Practice

JOHN TRICE, M.D.,* *Athens*

AN INITIAL GOAL of the psychiatrist should be to control his patients' overt symptomatology, predominant among which, in both neurotic and psychotic patients, are anxiety and depression. The symptoms of anxiety, in particular, are a major obstacle to treatment, for severely anxious and agitated patients are incapable of participating in communicative processes and of cooperating with the psychiatrist to a satisfactory degree. Control of these obstructive symptoms can be achieved in many cases with the use of an appropriate phenothiazine tranquilizer. In addition to relieving the patients' discomfort, such drug therapy can give them confidence in the psychiatrist's ability to help them and can thereby motivate them to continue in their treatment program. It seems, therefore, that phenothiazine treatment should be of benefit when employed in conjunction with psychotherapy, especially during the initial stages, as a means to facilitate patient-therapist communication. Promising results have been obtained from such use of one of these drugs, thioridazine,[†] in ambulant patients and are reported here.

Materials and Methods

Thirty-eight patients, 19 males and 19 females, were treated with thioridazine for periods ranging from one week to more than one year (average 6.9 months). They ranged in age from 18 to 80 years (average 39.2 years), with the women being older than the men (average, 47.0 years versus 31.4 years). Nineteen patients were married, 14 single, 2 divorced, and 3 widowed. The diagnoses are shown in Table I.

The criteria for prescribing thioridazine were anxiety and nervous tension of a degree which affected the patient's functioning within the community. A

TABLE I
DIAGNOSES OF PATIENTS

Schizophrenic Reaction	25*
Involutional Psychotic Reaction	3
Manic-Depressive Psychosis	1
Chronic Brain Syndrome With Psychosis	4*
Anxiety Reaction	3
Psychoneurotic Reaction	1
Personality Disorder	1
Total	38

* Including one patient with epilepsy as well.

global assessment of each patient's illness (as severe, moderate, or mild) was made before treatment was initiated. Starting dosage was individualized according to the severity of each patient's illness and ranged from 30 to 400 mg per day (average, 115 mg per day). When necessary, the dosage was adjusted within this range until symptoms were controlled. Psychotherapy, ranging from intensive to supportive, was conducted with patients when indicated and was modified throughout the treatment program according to the changing needs of each patient. Epileptic patients continued to receive appropriate anticonvulsant medication. Two other patients were prescribed barbiturates for various periods, one patient for vomiting and the other for sedation.

For purposes of statistical analysis, the severity of 18 target symptoms was graded on a four-point scale: 1 = absent, 2 = mild, 3 = moderate, and 4 = severe. Ratings were made before and at the conclusion of treatment; a third rating was made at some time during each patient's course of treatment. (In some instances, patients were not available for all three ratings.) From these individual scores, average severity was calculated for each symptom as it appeared before treatment, during treatment, and at the conclusion of the study. At the final rating, a

* Assistant Professor of Psychiatry, University of Georgia, Athens, Georgia, Director, Avalon Psychiatric Clinic, Athens, Georgia.
[†] Mellaril, Sandoz Pharmaceuticals.

TABLE II
RESULTS BY INDIVIDUAL TARGET SYMPTOMS

Target Symptoms	No. of Patients With Symptom Before-Treatment	Pre-Drug	Average Severity Interim On-Drug Rating	Final Rating
Anxiety	38	3.82	2.71*	1.90*
Nervous Tension	38	3.82	2.71*	1.90*
Apprehension	38	3.76	2.68*	1.77*
Restlessness	38	3.76	2.74*	1.84*
Confused States	21	3.43	2.24*	1.65*
Tremor	2	3.00	3.50	2.50
Paresthesia	1	4.00	4.00	4.00
Violent Outbursts	8	3.13	2.00*	1.71*
Destructive Behavior	4	3.50	1.25*	1.33*
Poor Impulse Control	11	3.91	2.82*	2.00*
Insomnia	32	3.50	2.34*	1.52*
Headaches	5	3.40	2.20	1.25*
Dizziness	4	3.75	1.50*	1.33*
Sighing Respiration	8	3.25	2.63*	1.75*
Heart Consciousness	4	4.00	3.00	3.00
Crying Spells	13	3.38	2.38*	1.18*
Delirium	6	3.33	2.33*	1.17*
Hallucinations	10	3.70	2.50	1.00*

* Significant improvement over pre-treatment severity (p<0.05; one-tailed Student t-test).

global assessment of illness (severe, moderate, or mild) was made and compared with that made prior to treatment.

Results

Presenting symptoms varied in incidence and degree, but it is worthwhile to note that anxiety, restlessness, apprehension and nervous tension were present in all patients and that insomnia and confused states occurred in most (Table II). All of these improved significantly after treatment (Student t-test). This was ascertained by comparing the average severities of each symptom for each of the three ratings. For example, average severity of anx-

iety declined from 3.82 (severe) to 2.71 (moderate) and finally to 1.90 (mild) by the end of the study. There was a significant reduction in the severity of all but four symptoms at the first on-drug rating and in all but three symptoms by the end of the study.

Review of the results suggested that the women may have responded better and showed this response earlier during treatment than the men. Statistical comparisons of the improvements obtained in certain symptoms were found to confirm this impression (Table III). (Note: The comparison was limited to nine target symptoms for which there were pretreatment ratings in at least 10 patients. This re-

TABLE III
COMPARISON OF SYMPTOM IMPROVEMENTS
IN MALE AND FEMALE PATIENTS

Symptom†	Males	Average Reduction in Severity	
		Comparison of Pre-Drug to Interim Rating Females	Comparison of Pre-Drug to Final Rating Males Females
Anxiety	0.95	1.26‡	1.94 2.00
Nervous Tension	0.95	1.26‡	1.94 2.00
Apprehension	0.89	1.26*	2.00 2.14
Restlessness	0.84	1.21‡	1.82 2.14
Confused States	0.91	1.50‡	1.40 2.43*
Poor Impulse Control	1.00	1.17	1.60 2.20
Insomnia	0.81	1.50*	1.86 2.18
Crying Spells	1.00	1.00	2.00 2.13
Hallucinations	0.83	1.75	2.40 3.00

* Significantly better reduction (p>0.05; two-tailed Student t-test).
† Symptoms compared were only those present in 10 or more patients of the total 38.
‡ Better reduction approaching significance (0.05 < p < 0.10; two-tailed test).

striction was used in order to avoid reaching general conclusions on the basis of two few cases.)

Improvements

At the first on-drug rating, the improvements in two of these nine symptoms, apprehension and insomnia, were significantly better for female than for male patients. Improvements in anxiety, nervous tension, restlessness, and confused states bordered on significance, again in favor of the female patients. By the final rating, however, differences in symptom improvement were almost nonexistent. For only one symptom of the nine, confused states, was the change significantly better in female patients than in male patients. At neither rating period did the men show greater improvements than the women.

After the final rating, the global estimates of overall illness in each patient before and after treatment were compared (Table IV). Twenty-seven patients were judged to be noticeably improved; five of eight patients had progressed from moderate to mild, 20 of 30 from severe to moderate, and two of 30 from severe to mild illness. The conditions of the remaining 11 patients were unchanged.

Thioridazine was well tolerated, side reactions being mild and transient. They consisted of drowsiness in six patients, and in one patient an increased tremor of the arm. Thioridazine was discontinued in one patient who persisted in "social drinking," despite instances of drowsiness, and in another whose leukocyte count dropped below normal values. However, in the latter patient treatment was reinstated when a subsequent white cell count was found to be normal.

which permits the patient to cooperate with his therapist. At the same time, however, complete symptom relief is not necessarily desired. The patient free of most feelings of anxiety, for example, may have little motivation for further treatment even though his mental status warrants it. Drug therapy also should not interfere with the patient's alertness, since his capacity to participate in psychotherapeutic processes must be preserved for meaningful treatment results. Finally, side effects must be minimal. In these terms, as demonstrated in this study, we have found thioridazine to be especially useful with both neurotic and psychotic patients.

For the neurotic patient, this drug has been employed chiefly during the early states of psychotherapy. Once anxiety and associated symptoms are sufficiently alleviated, the dosage is generally reduced. Drug therapy can often be discontinued if the therapeutic program progresses satisfactorily, with the patient gaining in self-awareness and emotional maturity.

For the severely disturbed patient with a psychosis or borderline psychosis, our effort is directed primarily to returning him to functional status and preventing hospitalization. Consequently, relief of overt psychotic symptoms is an immediate objective. Once these symptoms are brought under control, psychotherapy can be instituted. Through psychotherapy and continuing drug therapy with an agent such as thioridazine, the deteriorated personality defenses and behavior pattern of many psychotic patients can be restored to premorbid levels. These patients then can begin the process towards reintegration into family and community life.

Usefulness of Thioridazine

In our experience, the usefulness of thioridazine as an adjunct to psychotherapy is due primarily to its capacity to alleviate rapidly the disruptive symptoms of anxiety and without producing significant untoward effects. This impression was confirmed in the study reported here. The symptoms of anxiety, nervous tension, apprehension, and restlessness were significantly improved at both the interim and final ratings. As a corollary to this result, perhaps, patients' complaints to the psychiatrist (e.g. insomnia), their disruptive or aggressive behavior (e.g. violent outbursts), and their somatic manifestations (e.g. sighing respirations) were also substantially alleviated. It was interesting to note as well the beneficial effects of treatment on psychotic manifestations. Delirium, hallucinations, crying spells, and confused states, rated as moderately severe before treatment, were significantly improved at both the interim and final ratings.

Whether women tend to respond better and more

TABLE IV				
A. Global Evaluations of Illness				
Pre-Treatment Severity	Number of Patients With Post-Treatment Severity of:			
	Mild	Moderate	Severe	
Mild	—	—	—	
Moderate	5	3	—	
Severe	2	20	8	
B. Summary of Clinical Improvement				
	No. of Patients Whose Illness Was:			
	Severe	Moderate	Mild	Total
Before Treatment ..	30	8	0	38
After Treatment	8	23	7	38

Discussion

Drug therapy which provides an effective degree of symptom control without significant untoward effects can be a useful adjunct to a psychiatric treatment program. The severity of overt symptoms, particularly those of anxiety, must be reduced to a level

rapidly to this drug than men cannot be concluded from this study. The comparatively small number of patients must be considered here as a possible source of bias. Other reports on individual studies have appeared from time to time which suggest that different types of response may occur for the sexes. However, possible reasons for such differences, to our knowledge, have not been reported and, therefore, seem to be a topic worthy of investigation.

Clinical effectiveness similar to that observed in this study with the use of thioridazine has been described by other investigators. Wright,¹ Kinross-Wright,² and Tonken,³ found this drug highly effective and well tolerated in outpatients exhibiting a variety of mental disorders (in many cases, these had necessitated hospitalization previously) as well as less severe emotional disturbances. Studies of thioridazine with psychotherapy have shown that added benefits are obtained with the combined treatment.^{4, 5}

One problem frequently encountered in treatment with most phenothiazines is the occurrence of extrapyramidal reactions. These effects are especially critical in the ambulatory patient since they cannot be controlled easily and may aggravate his mental disturbance. Fortunately, such side effects are rare with thioridazine and none were seen in this study. This can exert a favorable influence on treatment for, as Cohen⁶ has noted, the schizophrenic disorder may

be aggravated by the effect of extrapyramidal stimulation on motor control and body image. Noteworthy also with thioridazine was the lack of an obtundent effect which has been observed with other phenothiazines. This was felt to be a substantial benefit since patients were sufficiently alert to participate in the psychotherapeutic program.

Summary

This study has demonstrated that thioridazine is a useful agent in the office treatment of various types of mental disorders. By rapidly alleviating symptoms, notably those associated with anxiety, thioridazine enhanced patient-psychiatrist communication and proved to be a valuable adjunct to psychotherapy.

150 Talmadge Drive

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6. Wright, G.: The treatment of non-hospitalized schizophrenics, *Am. J. Psychiat.* 119 (3):261, September 1962.

HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL AUGUST 16, 1970

Committee Conclave: Executive Committee received reports from Chairmen of Standing Committees as follows:

Allied Health Careers: Announced employment of Executive Secretary for Health Careers Council.

Maternal and Infant Welfare: Approved abortion survey to be mailed to all MAG members.

Nursing Liaison: Announced plans to make survey of student nurses and recently graduated nurses for subsequent report to House of Delegates.

Constitution & Bylaws: Heard two draft proposals to make MAG membership available to qualified osteopaths.

Crippled Children: Heard and approved request that the report on the Crippled Children's Program prepared by the Medical Care Administration Committee of the Health Department be tabled.

Rural Health: Advised that GRMP request for preceptorship program for GP's was disapproved, but

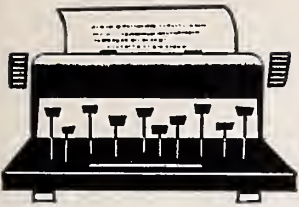
learned that GAGP is working on preceptorship program.

School Child Health: Received and referred to Council a request for additional \$2,000 for Committee programs previously approved.

Medical Review & Negotiating: Announced that a Policy Manual on Peer Review will be submitted to Council for approval.

Appointments: Drs. Victor Moore, Augusta, and William Nichols, Canton, were appointed to Medical Education Committee. Dr. Luther Fortson, Marietta, has accepted Chairmanship of the Medical Education Committee, and Dr. M. C. Adair, Washington, has accepted the position of GRMP Coordinator.

September Executive Committee and Council Meeting: It was noted that the Executive Committee would meet on September 19, 10:00 a.m., TV Room, Cloister Hotel, Sea Island, and that Council would meet the same day at 2:00 p.m.

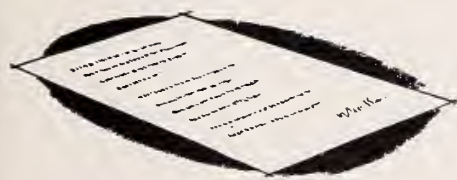


Medical Aspects of Sports

THE MEDICAL ASPECTS OF SPORTS CONFERENCE was held Friday, August 7, 1970, at the Dempsey Hotel, Macon, Ga. The Conference was sponsored through the Medical Association of Georgia School Child Health Committee, and is an annual post-graduate course. A luncheon, jointly sponsored by the Coca-Cola Company and M.A.G., featured a discussion of "Nutrition for the Athlete," and attracted over 200 coaches and physicians.

The 1970 Conference was designed to help team physicians and coaches to prepare for and handle medical problems and injuries of the athlete. Some of the areas covered were "Subluxation and Dislocation of Patella" by Jack Hughston, M.D., Orthopedic Surgeon, Columbus; "Proper Fitting of Protective Equipment" by Pat Dyer, Head Athletic Trainer at Georgia Tech; "Diagnosis and Treatment of Ankle Injuries" by George Whatley, M.D., Columbus; "Conditioning and Heat Adaptation" by Fred L. Allman, Jr., M.D., Atlanta; and "Knee Rehabilitation" by Ron Peyton, R.P.T., member of the National Athletic Trainers Association.

The School Child Health Committee has as its functions stimulating cooperation by individual physicians in School Health Programs, informing the profession on School Health Problems, and encouraging sanction from the medical profession of a sound school health program.



ABSTRACTS BY GEORGIA AUTHORS

Hossain, Zakir, M.D., and Wilk, Howard, M.D., Battey State Hospital, Rome, Ga. "Meckel's Diverticulum in an Adult with Massive Bleeding," Del. Med. J., 41:321-323 (Nov.), 1969.

A Meckel's diverticulum is said to be present in 2 per cent of all post-mortem examinations. Most patients with this anomaly live a normal life. In a small percentage, its presence may be heralded by serious complications. They become a diagnostic challenge when present. Massive bleeding is most often associated with heterotopic gastric and pancreatic mucosa producing peptic ulceration.

Case Report: The patient was a 21-year-old white male admitted with the chief complaint of fainting and tarry stools for three days. Past history was negative. Physical examination was negative except for pale sclera and tarry stool.

Admission hemoglobin was 5.5 grams, hematocrit 15 per cent and RBC 1.7 million. Other laboratory studies were normal. Sigmoidoscopic examination revealed dark clotted

blood. Upper G.I. revealed a channel ulcer. The patient was transfused and started on ulcer regimen improving significantly, but had repeat episodes of G.I. bleeding on second and third hospital days.

Abdominal exploration revealed source of bleeding to be an ectopic ulceration at the base of a Meckel's diverticulum which measured 3x5 cm. Gastric and pancreatic mucosa was found at its base. A wide segmental resection of ileum including the diverticulum was performed.

Zucker, Stanley, M.D., and Brosius, Effie, M. T. (ASCP), U. S. Dept. of HEW, Public Health Service, N.C.D.C., Atlanta, Ga. 30333. "Preparation of Quality Control Specimens for Erythrocyte Counting, Hematocrit and Hemoglobin Determinations," Amer. J. of Clinical Pathology, 53:474-480 (April), 1970.

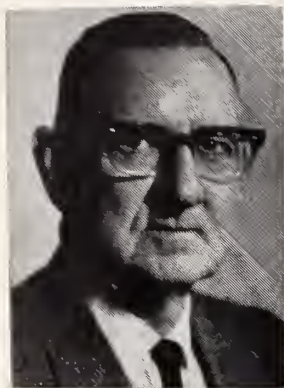
This report describes a new method for producing a stable erythrocyte suspension for use in the quality control of erythrocyte counting and hematocrit and hemoglobin determinations. Pro-

longed erythrocyte stability was produced by adding adenine, hydrocortisone, Phenergan, and Cohn's (plasma) fraction IV to red cells suspended in a modification of citrate-phosphate-dextrose solution. The method produces a relatively inexpensive and easily resuspended cell control, similar to fresh whole blood. Erythrocyte counts and hematocrit and hemoglobin determinations are stable for 30 days.

Rivers, Shirley L., M.D., and Patno, Mary Ellen, Ph.D., Dept. of Med., Emory U. School of Medicine, Atlanta, "Cyclophosphamide vs. Melphalan in Treatment of Plasma Cell Myeloma," JAMA 207:1328-1334 (Feb.17)1969.

The Veterans Administration Cancer Chemotherapy Group and the Pacific Veterans Administration Chemotherapy Group compared daily oral cyclophosphamide and melphalan in the treatment of plasma cell myeloma, in a randomized double-blind study.

Of the 150 patient studies, 33 were inadequate trials and 14 patients were removed.



DID YOU KNOW THAT . . . ?

THE AMERICAN MEDICAL ASSOCIATION was organized 123 years ago (1847) in Philadelphia when 250 physicians met with a single and simple purpose: "To promote the science and art of medicine and the betterment of public health." The primary intent was to improve the education of medical practitioners, and to establish a code of ethics for the medical profession.

These physicians could not know, and certainly never dreamt of, the myriad roles the American Medical Association was to play in the decades to follow.

For nearly a century and a half, the A.M.A. has striven to improve medical education collectively and to produce more physicians by loans to medical students. It has investigated and exposed quackery and nostrums and aided in legislation for improvement in the medical fields. It has been active in evaluation of foods, drugs, and pesticides. Diligent efforts have been made to improve health and safety in the home, factory, and on our highways.

Since its founding, the A.M.A. has worked for legislation which would control environmental pollution; as early as 1849 it attempted to evaluate drugs and medication and to thereby strengthen pure food and drug laws. Since 1878, it has sought to improve health education of the public and, in 1882, it urged teaching of hygiene in the schools.

You may be surprised to learn that the American Medical Association leadership was instrumental in bringing about such benefits to the public as enriched flour, canned baby food, iodized salt, vitamin enriched fruit juices and milk, safer cosmetics, and many other innovations now taken for granted.

Looking backward to 1847, the A.M.A. records an impressive number of hits and runs, but it has also committed errors, from which it has learned. One error continually returns to haunt the Association. In the 1950's the A.M.A. issued a denial of a physician shortage, based upon the findings of a staff economist who conducted a study of physician population and distribution. His calculations, unfortunately, did not include allowances for the 1960 surge in the demand for health care. The A.M.A. position of the 1950's changed in 1967 and a policy was adopted based on the recognition that there is an acute shortage of physicians and other personnel in the health care field. The A.M.A. is striving diligently to correct its previous mistake.

Another serious error was its failure to recognize the escalating cost of medical and hospital care and to lead the way in the aid to find better methods to moderate these costs. The House of Delegates and Board of Trustees acted affirmatively to urge members to take every action possible to protect the pocketbook of the health care consumer. (Physician's fees compose some 11 per cent of total medical health care cost, and physician's fees have increased some 18.2 per cent in the past five years, an average of 3.6 per cent per year.)

Again, the A.M.A. "goofed" in overlooking the financial problems of medical schools and, again belatedly, in 1967 it realized and admitted that if the approximately 100 existing medical schools were to remain open and new medical schools organized, federal funding would be necessary. The disproportionate support of research in medical schools by the National Institute of Health led to a serious imbalance resulting in a dearth of funds for operation of medical schools. Dr. Egeberg, Assistant Secretary of Health, Education and Welfare, told the members of the Organization of State Medical Presidents meeting in Denver last November, that 17 of the medical schools were virtually bankrupt. Those of you who have sons in medical school know the expenses of the student are not cheap, and your contribution is less than 20 per cent of the overall cost.

In the field of legislation, the A.M.A. was accused unjustly of being in opposition to group practice in voluntary health insurance in the 1930's. In fact, as far back as 1913, the A.M.A. helped develop plans for voluntary health insurance and prepayment plans as the best mechanism for payment for medical and hospital care.

Like it or not, the A.M.A. has been pulled closer to the government with its intrusion into the field of health care and medical matters. We, as physicians, would be abdicating our responsibility if we did not give advice and assistance in the provision of health care under the governmental programs. It is true that A.M.A. opposed the Medicare Law, but not for the reasons usually attributed to it. It opposed Medicare legislation because it was, and is, financed by the most regressive of all taxes, the payroll tax. The A.M.A. opposed Medicare legislation because it provided low cost, or free, care for everyone over 65 regardless of ability to pay, thus making the program needlessly expensive, with all those under 65 paying for it!

We, as physicians, opposed the Medicare legislation because it gave too much power to the federal government to regulate and control the practice of medicine. At the time, the A.M.A. offered an alternate plan called "Eldercare" which would have provided more benefits without compromising the physician-patient relationship. Although many opinion polls showed strong support for "Eldercare," it lost out when Congress voted.

Organized medicine, the American Medical Association, accurately predicted the fallacies of Medicare. As a result, legislators are listening and will continue to listen to its advice and counsel, knowing the information will be accurate, factual and complete.

With this rather brief resume of our parent organization, the American Medical Association, it is my privilege to inform each member of the Medical Association of Georgia that, at the present time, a complete brochure is being prepared for distribution to new members and prospective members. It will probably be presented to senior medical students, graduate students and residents giving the benefits possible to each member of the Medical Association of Georgia. Such information will go not only to prospective new members, but also to all members of the Medical Association of Georgia.

Information regarding benefits, privileges and responsibilities of membership in the Medical Association of Georgia will be disseminated and will likely be the subject of a subsequent letter.



*F. G. Eldridge, M.D.
President, Medical Association of Georgia*



IATROGENIC HEART DISEASE

HARRY T. HARPER, JR., M.D., *Augusta*

THE TERM IATROGENIC HEART DISEASE means physician-engendered heart disease. This might be modified to include heart disease which has been contributed to by the physician. The physician may contribute to such by mislabelling patients so far as their diagnosis is concerned, misinterpretation of physical signs and symptoms, overreading the electrocardiogram or x-ray, the unwise use of drugs and by the use of prosthetic devices.

Mislabelling Patients

Applying the incorrect label to a patient can produce severe anxiety with cardiac somatization and result in inestimable and permanent damage. This is especially true of the label of coronary disease. A patient mislabelled as having coronary disease may have a disability far exceeding that resulting from true angina and it may become almost impossible to remove the incorrect label. Chest pain occurring during hyperventilation episodes is often mislabelled as angina. The physician must be sure before he labels. If not sure, he must employ prolonged patient observation, consultation and the appropriate diagnostic tests until the diagnosis is apparent. No family or patient will object to this latter course.

Misinterpretation of Physical Signs and Symptoms

The incorrect interpretation of a systolic murmur is important. Many an insignificant systolic murmur has been labelled significant and an incorrect diagnosis and prognosis applied to the patient. Benign arrhythmias may be considered to be serious ones, e.g., sinus arrhythmia, ectopic beats, sinus tachycardia, paroxysmal supraventricular tachycardia and nodal or junctional rhythms (not due to digitalis). Edema is frequently non-cardiac. One need only mention the gravitational edema of obese middle-aged females in warm weather, the edema of venous insufficiency and lipedema to realize how often mistakes have been made. Dyspnea may be functional (classical "sighing respirations") or due to chronic pulmonary disease rather than the true exertional dyspnea caused by organic heart disease and left ventricular failure.

Overreading the Electrocardiogram and X-Ray

Everyone should be familiar with the fact that ST segments and T-waves are extremely labile. They may be influenced by emotions, hyperventilation, electrolytes, drugs, body posture and many other factors. The profound T-wave changes seen in subarachnoid hemorrhage and other central nervous system lesions may imitate those due to grave cardiac lesions. Acute pancreatitis may induce ECG patterns that mimic acute currents of injury due to myocardial infarction.

Pseudo cardiomegaly is frequently seen in the x-ray. In children, this may be due to a high diaphragm with inadequate inspiration at the time of exposure. Fluoroscopy of the chest or oblique views with more attention to respiration will clarify this. Pectus excavatum, kyphoscoliosis and the straight back syndrome can all produce the x-ray picture of pseudo cardiomegaly.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Unwise or Incorrect Use of Drugs

Digitalis is the great offender in this respect. Overdosage of this valuable drug may produce arrhythmias ranging from simple ectopic beats to high grades of A-V Block, junctional rhythms, paroxysmal tachycardias (supraventricular or ventricular) and ventricular fibrillation. The vigorous and unmonitored use of diuretics with digitalis is especially prone to produce electrolyte imbalance, arrhythmias and refractory heart failure.

Steroids may be necessary in selected instances, but often the dosage is not monitored properly or reduced promptly and sodium retention, hypertension, hyperglycemia, peptic ulceration, psychosis or activation of tuberculosis may result.

Finally, the use of prosthetic devices (valves) may produce complications, including thromboembolism, hemolytic anemia and infectious endocarditis. The introduction of cardiac pacemakers, while life-saving in most instances, may also result in catheter perforation of the myocardium and the production of fatal arrhythmias.

The physician must constantly exert every vigilance to prevent iatrogenic heart disease, thereby protecting his patient from needless disability and himself from undesirable criticism or even medicolegal action.

1467 Harper Street

METROPOLITAN PSYCHIATRIC CENTER

Accredited by the Joint Commission on Accreditation of Hospitals

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ATLANTA, GEORGIA 30308

Metropolitan Psychiatric Center, a private psychiatric hospital, provides individualized care for the treatment of emotional disorders. The Center is designed to provide the most functional and pleasant residential environment for psychiatric treatment. Central air conditioning, music in each room, and colorful furnishings provide a cheerful atmosphere conducive to rapid recovery.

The center is staffed by highly qualified psychiatrists and supported by a consultant staff of other medical specialists. Staff privileges are extended to all local psychiatrists who meet proper professional qualifications.

Additional information may be obtained by contacting the hospital by letter or telephone. Metropolitan Psychiatric Center is a member of The American Hospital Association, Georgia Hospital Association, National Association of Private Psychiatric Hospitals, and Metropolitan Atlanta Hospital Council.



VOLUNTARY STERILIZATION LAW RECOMMENDED FORMS

JOHN L. MOORE, JR. and TRAMMELL E. VICKERY,* *Atlanta*

ACT NO. 1288 OF THE GENERAL ASSEMBLY OF GEORGIA of 1970 became effective on July 1, 1970. It allows the performance of sterilization procedures on a voluntary basis on a wider group of patients than allowed by the 1966 Voluntary Sterilization Act. In addition, the 1970 legislation allows the performance of a sterilization procedure, in carefully restricted circumstances, on certain incompetent persons.

Requirements Outlined

Section 2 of the Act clearly sets out the requirements to be met with respect to competent individuals who wish to be sterilized. The pertinent part of Section 2 reads as follows:

"It shall be lawful for any physician . . . acting in collaboration or consultation with at least one other physician . . . and so requested by any person twenty-one (21) years of age or over, or less than twenty-one (21) years of age if legally married, to perform upon such person a sterilization procedure, provided a request in writing is made by such person and by his or her spouse, if married, and if such spouse can be found after reasonable effort, and provided, further, that prior to or at the time of such request a full and reasonable medical explanation is given by such physician to such person as to the meaning and consequence of such operation."

The Act specifically states that compliance with it is not necessary if the procedure involves medical or surgical treatment for sound therapeutic purposes which treatment may involve the nullification or destruction of the reproductive function at the same time that it serves such sound therapeutic purposes. Therefore, where the prime purpose of the procedure is sterilization only the physician and, if the procedure is to be performed in a hospital, the hospital should be certain that the following requirements are met.

1. A determination must be made as to the age and marital status of the person requesting the procedure. If the patient is over 21 and unmarried, only the patient's request is necessary. If the patient should be less than 21 and unmarried, the procedure may not be performed unless the patient is incompetent and the court procedures later described in this Article are followed. If the patient is over 21 and married, both the patient and the patient's spouse should request the procedure. If the patient is under 21 but married, the request of both the patient and the patient's spouse will be necessary. In addition, it is recommended that the physician consult his legal counsel to be satisfied as to the legality of the marriage.

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia. Mr. Vickery is a member of the firm of Jones, Bird & Howell, General Counsel to the Georgia Hospital Association.

2. The written request and consent of the patient must be obtained. If the patient is married and the spouse can be found after reasonable effort, the spouse must also sign the written request. If the patient is married but the spouse cannot be found after reasonable effort, the procedure may still be performed but separate forms must be used.

3. In all instances there must be "collaboration or consultation" with at least one other physician who must give his written agreement with the performance of the procedure.

4. With respect to competent persons, there is no requirement that the procedure be performed in a hospital. Obviously, especially with respect to the procedure on the female, good medical practice may require performance in the hospital. The procedure must be "any procedure or operation which is designed or intended to prevent conception and which is not designed or intended to unsex the patient by removing the ovaries or testicles."

Sterilization of Incompetents

Section 3 of the 1970 Act allows the performance on persons, whether or not 21 years of age, who, because of mental retardation, brain damage, or both, are irreversibly and incurably mentally incompetent to the degree that such persons with or without economic aid (charitable or otherwise) from others could not provide care and support for one or more children procreated by them in such a way that such children could reasonably be expected to survive to the age of 21 years without suffering or sustaining serious mental or physical harm.

Because of the very specialized requirements in Section 3 requiring individual attention by legal counsel, it does not seem advisable in this article to suggest forms relative to the performance of sterilization procedures on such persons. The physician or hospital is referred to his own legal counsel.

Reasonable Medical Explanation

Where a sterilization procedure is to be performed upon a competent person, the statute requires a "reasonable medical explanation" by the physician to the patient and the patient's spouse, if any, as to the meaning and consequence of such operation. While the recommended forms contained in this article create evidence over the signature of the patient and the patient's spouse, if any, that such an explanation has been given, it is still strongly recommended that physicians have in hand a written explanation of the particular procedure and be able to say that in all instances that is the explanation always given to sterilization patients.

Spouse Cannot Be Found

The 1970 Act allows performance of the procedure on a married person without the consent of the spouse if the spouse cannot be found after reasonable effort. The forms contained in this article contain the assertion that the patient has made reasonable effort and has been unable to find the spouse. In addition, the physician certifies that he has checked with the patient, believes the patient has fully divulged all known information reasonably necessary to find the spouse, and that the spouse cannot be found. It is strongly emphasized that the physician and hospital have a duty to follow up any lead to locate the spouse if possible. Evidence should be placed in the patient's file of the efforts made by the physician or his representatives. The physician or his representatives should dictate memoranda of telephone calls made and the results of such calls, even if negative.

*Suite 1220
C & S Bank Building*

REQUEST FOR VOLUNTARY STERILIZATION PROCEDURE
SINGLE INDIVIDUAL

(Name of Patient) Date Time M.
I hereby request that Dr. and assistants of his choice, perform
on me the following operation:
.....
I represent and warrant that I AM NOT LAWFULLY MARRIED, and am twenty-one (21) years of age
or over, and understand that the physician named above, others acting in collaboration with him, his as-
sistants, and the hospital or establishment wherein the said operation is to be performed are acting in
reliance upon my statements.
The operation has been explained to me, and I understand, that this operation is intended to result in
sterility, although this result has not been guaranteed. I understand that a sterile person is NOT capable
of becoming a parent.
I have been informed by my physician of the nature of the operation to be performed, risks involved,
and the possibility of complications. I desire the performance of such operation, assume risks and conse-
quences involved and authorize the performance of said operation at
..... Hospital, or at
..... (State where operation is to be performed, if other than a hospital)
I voluntarily request the operation and understand that if it proves successful the results will be
permanent and it will thereafter be physically impossible for me to inseminate, or to conceive, or bear
children.
I understand that it will be necessary to use an anaesthetic in connection with the above operation, and
the risks involved have been explained to me. I hereby consent to the use of such anaesthetic.
.....
Signature of Patient

VOLUNTARY STERILIZATION PROCEDURE—SINGLE INDIVIDUAL
RECITAL OF PHYSICIAN AND COLLABORATION

I warrant that I am duly licensed without restriction to practice medicine and surgery in the State of
Georgia pursuant to Chapter 84-9 or Chapter 84-12 of the Code of Georgia of 1933, as amended.
I have examined (Patient) and have agreed that
said patient should be sterilized by the performance of the following operation (State Nature of Operation):
.....
and have so advised said patient.
I have given a full and reasonable medical explanation as to the meaning and consequence of such
operation to the said patient, and have explained to the said patient that the above stated operation, which
has been requested and consented to by the patient, in writing, is intended to result in sterility although this
result has not been guaranteed. I believe that the said patient understands that a sterile person is not
capable of becoming a parent.
The said patient has voluntarily requested the above described operation in writing and I believe that
the said patient understands the nature of the operation, risks involved, and possibility of complications
and that if the operation proves successful the results will be permanent and it will thereafter be im-
possible for the patient to inseminate or to conceive or to bear children.
I believe that the patient voluntarily requested the performance of the above described procedure, that
the request is not the result of any force or coercion by any person, that the patient is NOT lawfully
married, and that the patient is twenty-one years of age or older.
Signed
Medical Doctor

ACKNOWLEDGEMENT OF COLLABORATION

I,, warrant that I am duly licensed without
restriction to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 or Chapter
84-12 of the Code of Georgia of 1933, as amended, and that I am acting and have agreed to act in
collaboration or in consultation with the above named medical doctor in the performance of the stated
procedure on the above named patient, the same being by and with the patient's expressed consent, and
am in agreement that the above stated operation should be performed.
Signed
Date Medical Doctor

REQUEST FOR VOLUNTARY STERILIZATION PROCEDURE
MARRIED PERSONS—SPOUSE PRESENT

(Name of Patient) Date Time M.
I hereby request that Dr. and assistants of his choice, perform
on me the following operation:
.....
I represent and warrant that I AM LAWFULLY MARRIED, and understand that the physician named
above, others acting in collaboration with him, his assistants, and the hospital or establishment wherein
the said operation is to be performed are acting in reliance upon my statements.
The operation has been explained to me, and I understand, that this operation is intended to result in
sterility, although this result has not been guaranteed. I understand that a sterile person is NOT capable
of becoming a parent.
I have been informed by my physician of the nature of the operation to be performed, risks involved, and
the possibility of complications. I desire the performance of such operation, assume risks and consequences
involved and authorize the performance of said operation at
..... Hospital, or at (State where operation is to be performed, if other than a
hospital)
I voluntarily request the operation and understand that if it proves successful the results will be
permanent and it will thereafter be physically impossible for me to inseminate, or to conceive or bear
children.
I understand that it will be necessary to use an anaesthetic in connection with the above operation, and
the risks involved have been explained to me. I hereby consent to the use of such anaesthetic.
.....
Signature of Patient

STATEMENT OF SPOUSE

I hereby represent that I, am the lawful spouse of the
above named patient, signify hereby my request that the described operation be performed, acknowledge my
acceptance and receipt of the explanation given to the patient and to me, described more fully in detail
above, and fully and freely accept the risks of, and consent to, the operation described.
.....
Signature of Spouse of Patient

VOLUNTARY STERILIZATION FOR MARRIED PERSONS
SPOUSE PRESENT
RECITAL OF PHYSICIAN AND COLLABORATION

I warrant that I am duly licensed without restriction to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 or Chapter 84-12 of the Code of Georgia of 1933, as amended.

I have examined (Patient) and have agreed that said patient should be sterilized by the performance of the following operation (State Nature of Operation):

.....
and have so advised said patient.

I have given a full and reasonable medical explanation to the patient and spouse as to the meaning and consequence of such operation to the said patient, and have explained to them that the above stated operation, which has been requested and consented to by the patient and spouse, in writing, is intended to result in sterility although this result has not been guaranteed. I believe that the said patient and spouse understand that a sterile person is not capable of becoming a parent.

The said patient and spouse have voluntarily requested the above described operation in writing and I believe that they understand the nature of the operation, risks involved, and possibility of complications and that if the operation proves successful the results will probably be permanent and it will thereafter be impossible for the patient to inseminate or to conceive or to bear children.

I believe that the patient and spouse voluntarily requested the performance of the above described procedure, that the request of each is not the result of force or coercion by any person including the other, and that the patient and spouse are lawfully married.

..... Signed
(Date) (Medical Doctor)

ACKNOWLEDGEMENT OF COLLABORATION

I,, warrant that I am duly licensed without restriction to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 or Chapter 84-12 of the Code of Georgia of 1933, as amended, and that I am acting and have agreed to act in collaboration or in consultation with the above named medical doctor in the performance of the stated procedure on the above named patient, the same being by and with the patient's expressed consent, and am in agreement that the above stated operation should be performed.

..... Signed
(Date) (Medical Doctor)

REQUEST FOR VOLUNTARY STERILIZATION PROCEDURE
MARRIED PERSONS WHERE SPOUSE CANNOT BE FOUND

(Name of Patient) Date Time M.

I hereby request that Dr. and assistants of his choice, perform on me the following operation:

.....

I represent and warrant that I AM LAWFULLY MARRIED, and understand that the physician named above, others acting in collaboration with him, his assistants, and the hospital or establishment wherein the said operation is to be performed are acting in reliance upon my statements.

The operation has been explained to me, and I understand, that this operation is intended to result in sterility, although this result has not been guaranteed. I understand that a sterile person is NOT capable of becoming a parent.

I have been informed by my physician of the nature of the operation to be performed, risks involved, and the possibility of complications. I desire the performance of such operation, assume risks and consequences involved and authorize the performance of said operation at

..... Hospital.

I voluntarily request the operation and understand that if it proves successful the results will be permanent and it will thereafter be physically impossible for me to inseminate, or to conceive or bear children.

I understand that it will be necessary to use an anaesthetic in connection with the above operation, and the risks involved have been explained to me. I hereby consent to the use of such anaesthetic.

I warrant and represent that I do not know the whereabouts of my spouse despite reasonable efforts on my part to find him or her.

.....
Signature of Patient

VOLUNTARY STERILIZATION FOR MARRIED PERSONS
SPOUSE CANNOT BE LOCATED
RECITAL OF PHYSICIAN AND COLLABORATION

I warrant that I am duly licensed without restriction to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 or Chapter 84-12 of the Code of Georgia of 1933, as amended.

I have examined (Patient) and have agreed that said patient should be sterilized by the performance of the following operation (State Nature of Operation):

.....

.....

and have so advised said patient.

I have given a full and reasonable medical explanation to the patient as to the meaning and consequence of such operation to the said patient, and have explained to the patient that the above stated operation, which has been requested and consented to by the patient in writing, is intended to result in sterility although this result has not been guaranteed. I believe that the said patient understands that a sterile person is not capable of becoming a parent.

The said patient has voluntarily requested the above described operation in writing and I believe that the patient understands the nature of the operation, risks involved, and possibility of complications and that if the operation proves successful the results will probably be permanent and it will thereafter be impossible for the patient to inseminate or to conceive or to bear children.

I believe that the patient voluntarily requested the performance of the above described procedure, that the request is not the result of any force or coercion by any person, and that the patient is lawfully married.

I am satisfied that the above patient has fully divulged all known information reasonably necessary to find the spouse of said patient, that said spouse cannot be found and that reasonable efforts have been made to locate said spouse.

..... Signed
(Date) (Medical Doctor)

ACKNOWLEDGEMENT OF COLLABORATION

I,, warrant that I am duly licensed without restriction to practice medicine and surgery in the State of Georgia pursuant to Chapter 84-9 or Chapter 84-12 of the Code of Georgia of 1933, as amended, and that I am acting and have agreed to act in collaboration or in consultation with the above named medical doctor in the performance of the stated procedure on the above named patient, the same being by and with the patient's expressed consent, and am in agreement that the above stated operation should be performed.

..... Signed
(Date) (Medical Doctor)

THE ASSOCIATION



NEW MEMBERS

Albuquerque, L. John de Active—Fulton—SU	2739 Bayard East Point, Georgia 30344
Clark, John S. Active—Thomas-Brooks- Grady—P	314 N. Dawson Street Thomasville, Georgia 31792
Cohen, David M. Active—Fulton—OTO	6363 Roswell Rd., N.E. Atlanta, Georgia 30328
Cohen, Lawrence Active—Fulton—OBG	3312 Piedmont Rd., N.E. Atlanta, Georgia 30305
Craig, Frederick S. Active—Muscogee—OR	320 Doctors Building Columbus, Georgia 31901
Crisp, Nelida S. Active—Fulton—SU	4346 Roswell Rd., N.E. Atlanta, Georgia 30305
Croft, Thomas J. Active—Fulton—NS	2718 Felton Drive East Point, Georgia 30344
Davis, Shelley C., Jr. Active—Fulton—I	1365 Clifton Rd., N.E. Atlanta, Georgia 30322
Davis, Warren W. Active—Fulton—I	275 Carpenter Dr., N.E. Atlanta, Georgia 30328
Doxey, Clem M., Jr. Active—Cobb—D	702 Cherokee Street Marietta, Georgia 30060
Ellis, John W., Jr. Active—Cobb—GP	1323 Roswell Rd. Marietta, Georgia 30060
Forshner, John G. Active—Whitfield—D	1604 Murray Ave. Dalton, Georgia 30720
Gable, Thomas W. Active—Fulton—P	3400 Peachtree Rd., N.E. Atlanta, Georgia 30326
Gilbert, Charles A. Active—Fulton—I	69 Butler Street, S.E. Atlanta, Georgia 30303
Grush, Owen C. Active—Fulton—PD	69 Butler Street, S.E. Atlanta, Georgia 30303
Hollander, Leonard Active—Fulton—P	1317 Clifton Rd., N.E. Atlanta, Georgia 30307
Illig, William P. Active—Glynn—Path	Brunswick Memorial Hospital Brunswick, Georgia 31520
Johnson, Charles E. Active—Fulton—I	490 Peachtree Street, N.E. Atlanta, Georgia 30308
McLendon, Joe L. Active—Bibb—Oph	626 First Street Macon, Georgia 31201
Reeves, Martin M. Active—Fulton—Anes	2081 Jordon Terr., N.E. Atlanta, Georgia 30329
Rosen, Barrett F. DE-2—Whitfield—OR	Huntington Road Dalton, Georgia 30720

Rosen, Ronald
Active—Cobb—U

Santana-Bobadilla, P. A.
Active—Muscogee—Path

Spearman, William B.
Active—Fulton—I

Stephens, Robert O., Jr.
Active—Cobb—PD

Taylor, William E.
Active—Washington—GP

Wilhoite, James R.
Active—Clayton-Fayette
GP

Wofford, Benjamin H., Jr.
Active—Cobb—PL

Cherokee Medical Building
Smyrna, Georgia 30080

P. O. Box 951
Columbus, Georgia 31902

46 Fifth Street, N.E.
Atlanta, Georgia 30308

680 Church Street
Marietta, Georgia 30060

Smith Street
Tennille, Georgia 31089

6103 N. Main Street
Morrow, Georgia 30260

644 Cherokee Street
Marietta, Georgia 30060

SOCIETIES

The **DeKalb County Medical Society** has awarded its annual Nursing Scholarship to Miss Iris Bowden of DeKalb County. Miss Bowden received \$900 toward the expenses of attending Crawford W. Long School of Nursing.

PERSONALS

First District

O. Emerson Ham, Jr., has opened an office in Savannah for the practice of neurology.

William F. Kent of Adel has been named an associate of Charles R. Richardson of Statesboro, specializing in obstetrics and gynecology.

Second District

Oswaldo D. Benitez has opened an office for general surgery in Quitman.

Edwin Miller Griffin has been re-elected to active membership in the American Academy of General Practice.

Paul Lucas spoke to the Tifton Lions Club in July, predicting that socialized medicine will become nationalized, with the method of payment being the same as that for social security.

Third District

Jack C. Hughston attended a sports medicine seminar in San Francisco in August. The seminar was sponsored by the Committee on Sports Medicine, American Academy of Orthopaedic Surgeons.

Wallace Lucas has moved his office for general practice to Cochran from Eastman.

Fourth District

F. C. Nesbit was honored in July by the Covington

Service Guild and Rotary Club upon his retirement after 58 years in practice.

Fifth District

Paul Carleton Atwater has been elected president of the SAMA chapter of the Medical College of Georgia. **John S. Atwater, Jr.**, is in his first year of internship at the Mayo Clinic.

Ilhan M. Ermutlu has been named superintendent of the Georgia Regional Hospital at Savannah.

Alfred A. Messer delivered a lecture on Mechanisms of Family Homeostasis entitled "How Does a Family Maintain Its Equilibrium?," at the International Congress on Child Psychiatry, Jerusalem, Israel, in August.

Sixth District

George H. Alexander is retiring from practice in Forsyth after 45 years of service to that community.

Ninth District

Raleigh Garner has retired after 41 years of practice in Gainesville.

DEATHS

Ben E. Daniel

Ben E. Daniel died suddenly July 13 at his residence near Claxton. He was 52.

A native of Evans County and a member of the First Baptist Church of Claxton, he is survived by five sons: Ben F. Daniel, III, David F. Daniel, Jonathan Jones Daniel, MacArthur Hardin Daniel, and Luke Sahlman Daniel, all of Fernandina Beach, Fla.; a stepson, Hal Sahlman, of Fernandina Beach, Fla., a sister,

Mrs. W. H. Allen, Jr., of Claxton, and several nieces and nephews.

Robert Wayne Johnson

Robert Wayne Johnson, staff member of the Archbold Memorial Hospital, died July 14 after an extended illness. He was 61.

Mayor of Boston in 1967-68, Dr. Johnson was a member of the Thomas County Republican Executive Committee, Thomasville Kiwanis Club, Shrine Club and Masons. He was also a member of the Thomas-Brooks Medical Society, the Medical Association of Georgia and the American Medical Association.

He was graduated from Wartburg College, Clinton, Iowa in 1933 and received his M.D. degree from State University of Iowa in 1937.

Dr. Johnson is survived by his widow, the former Imogene Simons of Belton, Texas; his mother; a son, three daughters and a sister.

John B. Thompson

John B. Thompson, 68, died July 6 in Columbus.

He was graduated from Emory University Medical School and did postgraduate work at Presbyterian Hospital in Chicago, Rush Medical School (Chicago), and American Academy of Ophthalmology and Otolaryngology. He served as captain in the Army Medical Corps in North Africa.

Dr. Thompson was a member of the Columbus Country Club and the Big Eddy Club. He and his son, John Daniel Thompson of Atlanta, served as volunteer workers on the hospital ship HOPE in 1967.

Other survivors include his widow, Mrs. Marie Dykes Thompson, Columbus; a daughter, Mrs. William B. Turner, Columbus and 10 grandchildren.

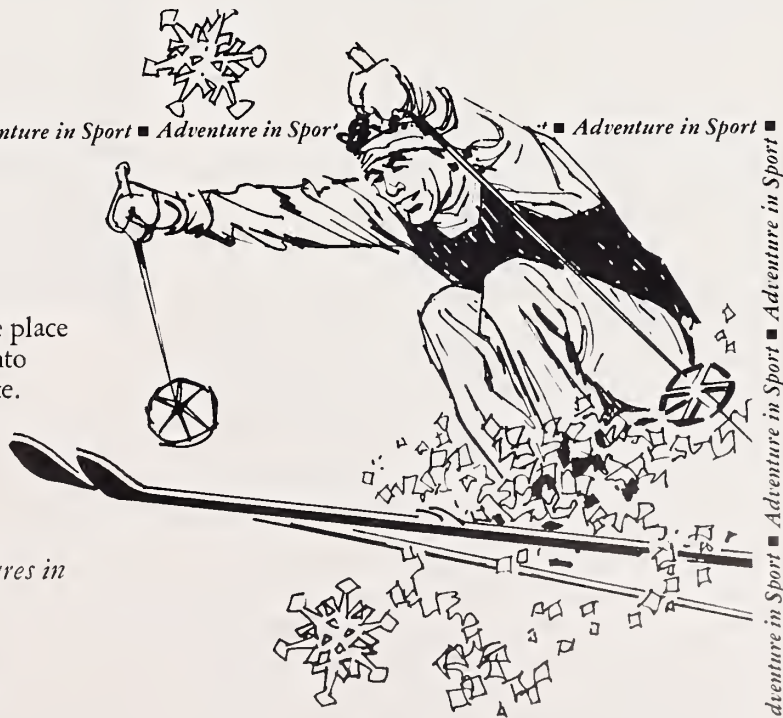
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■ Adventure in Sport ■

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THE MONTH IN WASHINGTON

A Democratic and a Republican member of the House Ways and Means joined to introduce the American Medical Association's Mediredit plan for federally subsidized national insurance.

The co-sponsors of the legislation (H.R. 14567) were Reps. Richard Fulton (D., Tenn.) and Joel T. Broyhill (R., Va.). Both are members of the House Ways and Means Committee which has jurisdiction over such legislation. Soon after introduction of the Fulton-Broyhill measure, Rep. Omar Burleson (D., Tex.), also a member of the Ways and Means Committee, and Rep. John Jarman (D., Okla.), chairman of the House Commerce Subcommittee on Health, introduced an identical bill. Other members of the house from both major political parties indicated they also would become co-sponsors.

Fulton, who 18 months ago introduced legislation based on the Mediredit principles for financing private health insurance for individuals, told the House that the new bill "represents . . . a vast improvement over its predecessor by reason of the fact that it encompasses a built-in mechanism for cost control." He referred to mandatory peer review.

Time for Change

Speaking for himself and the measure's co-author, Rep. Joel T. Broyhill (R., Va.), Fulton said the time for national health insurance has come.

"And whether we're talking about the Rockefeller approach, the AFL-CIO approach, the Kennedy approach, or the approach taken by the Committee of 100, all of them advocate sweeping changes in our health care system," Fulton said.

"An across-the-board national health insurance plan, operated regardless of need, will carry a price tag of sobering size. And no such plan I have yet seen includes—at least to my satisfaction—a mechanism which promises effective cost control of the taxpayers' money.

"This brings us to an essential element of Mediredit—its provision of peer review. This bill calls for a constant and unremitting policing mechanism."

Government Financing

The other two parts of the Mediredit legislation would provide for the federal government financing or assisting in the financing of medical and hospital care for individuals and their dependents through participation in the cost of insurance policies of their choice—100 per cent premium payment for the low-income groups, and graduated participation in the payment of premiums for other persons, based on their federal income tax liability.

Congress is not expected to take up this year proposals for national health insurance. But reaction to the AMA peer review plan has been highly encouraging, and prospects appeared good that Congress would approve such a plan this year for medicare and medicaid. Sen. Wallace F. Bennett (R., Utah), a senate finance committee member, directed the committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising medicare and medicaid.

Cost Concern

In a speech on the Senate floor, Bennett said there is deep concern over the high costs of medicare and medicaid. He complimented the AMA on advancing peer review as a means of curbing these costs. He said:

"I believe the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern and, more importantly, proposes to do something substantial about it through means of professional standards review organizations. . . .

"I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the Government would not need to devote its energies and resources to this area of concern. Make no mistake; the direction of House-passed social security bill is toward more, not less, review of

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the need for and quality of health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

Review Responsibility

Bennett said that, under his amendment, review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care." That responsibility, he said, would be lodged "wherever possible and wherever feasible," at the local community level. He said:

"Local emphasis is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review. . . .

"Under the amendment, the Secretary (of Health, Education and Welfare) could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only *pro forma* or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

Duties of Committees

Bennett said that the review committees should de-

termine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

Disciplinary measures, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

Concerning the peer review part of his bill—H.R. 18567, "Health Insurance Assistance Act of 1970"—Fulton said:

"The appropriate medical societies would be charged with establishing a peer review mechanism that would, among other things, review individual charges and services, wherever performed; review hospital and skilled nursing home admissions; review the length of stays in hospitals and skilled nursing homes; and review the need for professional services provided in the institution.

Salutary Effect

"The process of ongoing review can have nothing but a salutary effect on the providers of services, thereby cutting down on the occasional or unintentional abuses that would otherwise occur.

"Patterns of abuse would be detected, and the abusers either suspended from or excluded from the program. Exclusion could follow action by the Secretary of Health, Education and Welfare upon the recommendation of the peer review committee.

"In the case of fraud, or other clear intentional misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

"And in the event that a peer review committee was *not* established by the medical society within a reasonable time, or if established was not functioning, the Secretary of HEW, in consultation with the medical society, would be empowered to appoint a peer review committee that would function."

Certificate Benefits

The Fulton-Broyhill bill would provide that an individual having a tax liability of \$300 or less in a base year be entitled to a certificate acceptable by carriers for health care insurance for himself and his dependents. Insurance purchased with such a full-pay certificate would require no beneficiary participation in health care charges. Federal contribution to insurance purchased by individuals under this part of the program would be scaled in favor of low-income taxpayers—from 98 per cent if the taxpayer's base year income tax is between \$301 and \$325, to 10 per cent when his tax liability exceeds \$1,300. Basic benefits in a 12-month policy period would include 60 days of inpatient hospital care. To encourage utilization of less expensive facilities, two days in an extended care facility would count as one day of the 60 days allowed. Other basic benefits would include emergency and outpatient services, and all medical services provided by a doctor of medicine or osteopathy.

A supplemental coverage could provide, in addition, one or more of the following: prescription drugs not otherwise covered, additional days of inpatient and extended care services, blood in excess of three pints, personal health services when furnished on written direc-



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tion of a physician, diagnostic and therapeutic services, and catastrophic coverage of all hospital and medical costs, up to \$25,000, after the first \$300 of incurred expenses borne by the beneficiary.

Society Radio Services

The Federal Communications Commission approved an application for local medical societies to operate special emergency radio services for their members.

The FCC said that such hookups could carry only messages relating to the safety of life or urgent medical duties of users. Such emergency radio service must be cooperative, with members assessed *pro rata* shares for cost of operation, the FCC said.

Previously, individual physicians have been allowed to use emergency radio frequencies and to form groups of physicians for such hookups, but societies representing all physicians in an area have been restricted by FCC regulations.

The FCC said in its ruling:

"There is merit in the plan to use these stations on a coordinated basis with telephone answering services now operated by medical societies and to dispatch messages from central points where society records are readily available to assist in locating a physician when called. . . . The proposal gives promise of fostering the opportunities for service in remote, rural regions . . . (and) would permit the establishment of parallel systems for emergency communications which would be in existence and available for use in times of national crises."

Medical societies that petitioned the FCC include Academy of Medicine of Cleveland and Cuyahoga County, Fayette County, Fresno County, King County, Los Angeles, Maricopa County, Montgomery County, Oklahoma County, San Joaquin, Milwaukee County, Sacramento County, and Travis County. They were joined by the American Medical Association.

TENNESSEE VALLEY MEDICAL ASSEMBLY

The Tennessee Valley Medical Assembly will be held at the Read House, Chattanooga, Tenn., October 19-20, 1970. For further information, contact Don J. Russell, M.D., Chairman, 107 Interstate Building, Chattanooga, Tenn. 37402.

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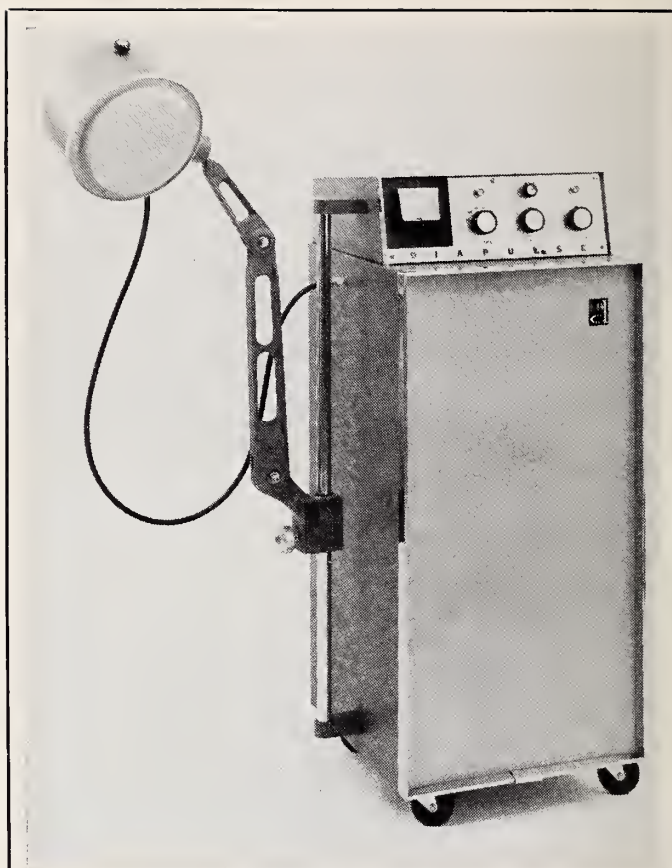
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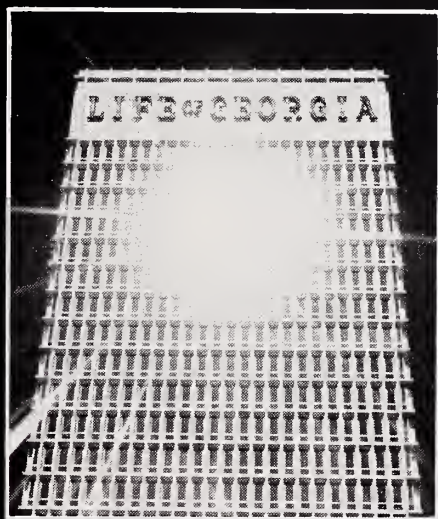
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SECOND FAMILY PRACTICE EXAMINATION SCHEDULED

The American Board of Family Practice announces that it will give its second examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 27-28, 1971. Information regarding the examination and eligibility for the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary-Treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40456.

PLEASE NOTE: Deadline for receiving completed applications in the Board office is November 1, 1970.

1971 ALBION O. BERNSTEIN, M.D. AWARD COMPETITION ANNOUNCED

The 1971 Albion O. Bernstein, M.D. Award for an outstanding contribution to the advancement of medicine has been announced by the Medical Society of the State of New York for presentation at its annual convention here next February 14-18.

The \$1,500 national award was established by Mr. Morris J. Bernstein of New York in memory of his physician son who died on November 23, 1940 while on an emergency hospital call. It is to be given to the physician, surgeon or scientist who shall have made the most widely beneficial scientific discovery in medicine, surgery or the prevention of disease during the period November 23, 1969 to November 23, 1970.

Nominations should be sent to the Awards Committee, MSSNY, 750 Third, New York, N.Y. 10017, no later than December 1, 1970.

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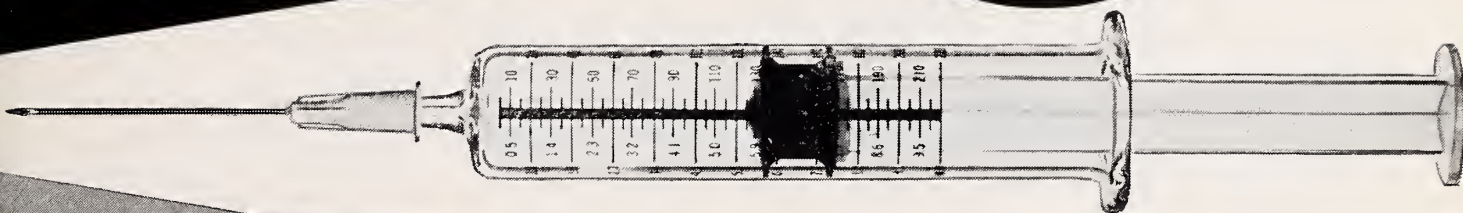
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Contents

Scientific Articles

LASER TREATMENT OF TATTOOS AND ANGIOMAS K. William Kitzmiller, M.D.	385
RUBELLA AND RUBELLA VACCINES: CURRENT CONCEPTS John J. Witte, M.D.	387

Special Article

THE RESPONSIBILITIES OF A COUNTY MEDICAL SOCIETY PRESIDENT Ronald F. Galloway, M.D.	392
---	-----

Editorial

IF YOU DON'T VOTE—DON'T GRIPE	395
---	-----

Features

President's Letter	396
Cancer Page	398
Heart Page	400
Legal Page	402
Month in Washington	412

The Association

New Members	408
Personals	408
Deaths	408
90 Years Ago	410

Cover

Design by Marie Seaman.

Where conventional treatment cannot be used, the laser is of clinical value in the treatment of these conditions.

Laser Treatment of Tattoos and Angiomas

K. WILLIAM KITZMILLER, M.D.,* Cincinnati

LASERS HAVE BEEN IN USE for the past decade. We have been particularly interested in the medical applications of laser light. Two entities have lent themselves to treatment with laser. These entities are tattoos and angiomas, both of the cavernous and portwine types. The reason they are amenable to laser therapy is because both are the result of pigmentation: in the case of tattoos, artificially induced pigments; in the case of angiomas, naturally occurring blood pigments such as hemoglobin. A laser beam is more readily absorbed in pigmented tissue such as exists in a highly pigmented tattoo or extremely vascular tumors such as the portwine or cavernous angiomas. The laser systems most frequently used in this type of therapy involve either the pulsed lasers, normal mode and Q-switched, or the so-called optical knives from a high output continuous wave laser operating in various wave lengths from blue green to the far infrared. Excessive exposure of normal surrounding skin is to be avoided.

Tattoos

There is still a need for relatively uncomplicated and rapid methods of tattoo removal. This need has been increased recently because of the increasing number of war casualties with tattooing from foreign bodies caused by land mine explosions. Other modes of therapy, including excisional surgery and dermabrasion as well as the introduction of flesh-colored pigments into the skin by tattoo processes, have not been particularly satisfactory. Irradiation of tattooed skin with radiation from the ruby (6943 Angstrom units), neodymium (10,600 Angstrom units), and argon (4880-5145 Angstrom units) lasers have shown that the beam is more readily absorbed in highly pigmented tattoo dyes. Studies have shown

that colored tattoo pigments will selectively absorb the visible laser and infrared beams even at relatively high energy densities, 50 to 75 j/cm² for the argon laser. Carbon dioxide lasers exhibit no color specificity as it is absorbed in a non-selective manner in both non-pigmented tissue and tattoo particles.

Studies have been under way now at the Laser Laboratory, Children's Hospital Research Foundation, for some six years. More recently there has been made available a segmented flexible transmitting arm which has greatly simplified the transmission of the argon beam. Emphasis is placed on eye protection of both the operator and the patient as the treatment is carried out. Pain is minimal and local anesthesia is required only in prolonged treatment with the high output argon lasers. The initial reaction is that of a charring and crusting corresponding to the area of the target. Oozing may occur for several weeks after the treatment until dried crusts form. After these crusts peel a flat, reddened area remains. The redness begins to fade after a month.

Estimated Efficacy

At this time, efficacy of laser therapy may be estimated. The progress is recorded by standardized color photographic techniques and biopsies. The only reactions observed have been those of secondary infection and hypertrophic scarring. In a previously reported series of 116 patients, hypertrophic scarring has occurred in only three patients. Secondary infection appeared to be a result of carelessness in the post-treatment care on the part of the patient. Studies have indicated that hypertrophic scarring seems to subside. This usually occurs approximately one year after treatment. Attempts were made at the time of initial therapy to avoid treating anyone who has a tendency toward keloid formation. The mechanism which causes the tattoo removal involves a localized vaporization of the dye particles which, in a gaseous form, are then expelled from the tissues

Presented at the Georgia Society of Dermatologists, held in conjunction with the 116th MAG Annual Session, May 7-10, 1970, Jekyll Island, Georgia.

*Research Associate, Laser Laboratory, Children's Hospital Research Foundation of the Medical Center of the University of Cincinnati.

LASER TREATMENT / Kitzmiller

as part of the laser reaction plume. To date there has been no evidence of malignant change in tissue as a result of the impact on tattoos by the laser. Results of laser treatments of tattoos have proven in the majority of instances to be cosmetically acceptable.

Angiomas

Portwine and cavernous angiomas have long been a therapeutic challenge. In the past, a great variety of therapies including surgery, excisional grafting, radiation, covering tattooing and dermabrasion have been employed. Cavernous angiomas, because of the natural course of events, will often subside spontaneously. Therefore, control evaluation of response to therapy is necessary. However, portwine lesions are resistant to all forms of therapy. The resistance to therapy of the portwine lesion has been attributed to the maturity and hamartomatous character of the cellular vascular elements of this lesion, as well as the extent and depth of many of the vascular structures. Laser systems employed in the treatment of angiomas include the ruby laser (6943 Angstrom units), neodymium, argon and carbon dioxide lasers. In a particular patient, a small test spot is selected. For the ruby lasers the average treatment is 55 to 65 j/cm² with a target area of approximately 1.76 cm² with a pulse duration of 2 to 3 milliseconds. There is initial charring period. The treated areas are observed for six weeks during which there is crusting, eventual peeling or desquamation of the crust and gradual fading of the redness. After sufficient testing to ascertain the effect of the laser on a par-

ticular angioma as well as evaluating the type of scar produced, further therapy is carried out. Reactions which have occurred include superficial transient atrophy, superficial scarring, increased redness of a transient nature and occasional revascularization. Hemorrhage has not been a problem. Some workers have stated that there is more residual radiation damages than persistent angiomas. Over the past six years of laser treatments, radiations sequela similar to those of x-ray or radium have not been observed.

As is the case with tattoos, the darker and thicker the angioma, the greater the response. It must be emphasized that this treatment is investigative and perhaps not even practical for a patient with an extensive lesion. Yet, the lightening in color even for a small area is persistent and usually cosmetically acceptable. A rule of thumb at present is, if you do not need the laser, do not use it. Studies done over the past six years have shown encouraging results which certainly warrant continued investigative studies for resistant and vascular lesions such as the portwine spots and those progressive and capillary and cavernous accessible angiomas. In a study reported recently, approximately some 200 cases of portwine angiomas were treated with improvement.

Conclusions

Continued evaluation of laser therapy in the treatment of angioma and tattoo is warranted. Experiences seem to indicate that where conventional treatment cannot be used, the laser is of clinical value in the treatment of selected angiomas and tattoos.

University of Cincinnati

Have faith in the Lord but use sulphur for the itch.

—Anonymous

POSTGRADUATE PROGRAMS

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces postgraduate programs leading to the degree of Master of Public Health. These programs are for pediatricians, obstetricians, and other physicians interested in receiving training in the field of Maternal and Child Health. Fellowship support is available, including basic support for the trainee, an allowance for dependents, tuition and fees.

Program areas now available include nine-month programs in Maternal and Child Health, Health of

School-Age Children, and Maternal Health and Family Planning. A 21-month program in Care of Handicapped Children, Perinatology, and Comprehensive Care is available. There are also three-year Career Development Programs in Pediatrics and Obstetrics which combine Public Health and Residency training. Fellowships are available for these programs also.

Applications are now being accepted for the group entering September, 1971. For information, write to Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

In time, rubella and congenital rubella syndrome may become as rare as smallpox and poliomyelitis.

Rubella and Rubella Vaccines

Current Concepts

JOHN J. WITTE, M.D.,* *Atlanta*

RUBELLA IS ONE of the common infectious diseases of childhood. It was first reported as a distinct disease entity early in the 18th century in Germany.¹ Subsequently, outbreaks were recognized in a number of countries in Western Europe and North America. However, because of the early interest displayed by German writers, this disease became known as "German measles." In 1866, a paper by Henry Veale appeared in the *Edinburgh Medical Journal*²; he described an outbreak of 30 cases and proposed the name "rubella." During the late 1930's the clinical characteristics of the disease became well defined. Outbreaks of rubella were noted in military recruits,³ boarding school students,¹ and other confined populations.⁴ While these were disruptive, they were hardly catastrophic. Rubella became accepted as one of the common, supposedly benign, infectious diseases of childhood.

In 1941, Norman McAlister Gregg, an Australian ophthalmologist, shattered the belief in the harmlessness of rubella by describing a series of 78 cases of congenital cataract with a maternal history of rubella during pregnancy.⁵ Fifty-four of these 78 children also had congenital heart disease, and other malformations were noted. Gregg also pointed out that most of the cases of congenital rubella syndrome were associated with rubella infection that occurred early in pregnancy. This report by Gregg has become a classic, as it established the clinical and public health importance of the disease.

The recognition of the severe teratogenic impact of rubella prompted efforts toward control. Isolation of the rubella virus in 1962 paved the way for the development of vaccines. In 1966, Parkman, Meyer, and their colleagues⁶ at the National Institutes of

Health succeeded in developing a live attenuated rubella virus vaccine. Derivatives of their strain as well as others developed more recently have been extensively studied and found to be safe and effective. In June 1969, rubella vaccine was licensed for use in the United States. With an effective control measure now available, it is appropriate to review the current status of rubella, estimate the probability of a major epidemic occurring within the next few years, and see how increasing vaccine usage may diminish this probability.

Incidence of Rubella

The incidence of rubella from 1928 to 1969 in 10 selected areas of the United States is shown in Figure 1. It is obvious that these rates vary greatly. Major epidemics occurred in all areas of the country in 1935, 1943, and 1964, and periods of high incidence were recorded in 1952 and 1958. These periods of high incidence occurred at six to nine year intervals, which suggests that rubella outbreaks occur at slightly variable but moderately long intervals. This cyclicity contrasts strikingly with the regular two-year periodicity of measles in the United States prior to large-scale use of measles virus vaccine. Although years of high rubella incidence tend to occur at six to nine year intervals, widespread epidemics occur less frequently. It is probable that the next peak period will be less severe than the 1964 experience. Rather, it is more likely that it will approximate the levels noted in 1958. This periodicity of rubella indicates that the next peak could occur as early as this year. However, current data on reported cases of rubella show that this will be a year of relatively low incidence.

The seasonal distribution of reported cases of rubella for the past seven years is shown in Figure 2. The number of reported cases begins to rise in early winter; reaches a peak in March, April, and May; and falls to a low point in the late summer and autumn. This seasonal pattern is maintained during pe-

Presented at the Annual Session of the Medical Association of Georgia, May 7, 1970.

* From the Epidemiology Program and Immunization Branch, Center for Disease Control, Health Services and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare, Atlanta, Georgia 30333.

RUBELLA INCIDENCE - TEN SELECTED AREAS,
U.S.A., 1928-1969

Table I
REPORTED CASES OF RUBELLA BY AGE AND SEX
FOR SELECTED AREAS*—1963-1967

Age	Number	Total %	cum. %	Number	Male %	cum. %	Number	Female %	cum. %
0-4	16,373	13.5	13.5	8,218	14.3	14.3	8,155	12.9	12.9
5-9	52,078	43.1	56.6	25,660	44.5	58.8	26,418	41.8	54.7
10-14	28,403	23.5	80.1	13,483	23.4	82.2	14,920	23.6	78.3
15-19	14,527	12.0	92.2	7,446	12.9	95.1	7,081	11.2	89.5
20-39	8,100	6.7	98.9	2,541	4.4	99.5	5,559	8.8	98.3
40+	1,363	1.1	100.0	286	0.5	100.0	1,077	1.7	100.0
Total	120,844			57,634			63,210		

bit renal cell cultures were also licensed. All three vaccines have similar properties. They are immunogenic and attenuated when administered to children. Although vaccinees shed virus from the pharynx for two or more weeks after vaccination, there is no definite evidence of communicability at the present time. Approximately 95 per cent of susceptible vaccinees develop antibodies; however, titers are lower than those observed following natural rubella infection.

Recent studies have shown that vaccine protects against clinical illness following natural exposure, but some vaccinees have significant rises in antibody titer, indicating reinfection.^{8, 9} At the present time, there is no documentation that any have developed viremia. Though some of these reinfected persons shed virus in their pharynx, it is only for very brief periods of time and in very low titers.⁹ There is no evidence that reinfected vaccinees spread virus to susceptible contacts.

Antibody levels have declined very little during the 4-year period of observation of children who were among the first to be inoculated with rubella vaccine. The duration of protection should be long; however, this will be established only by continued observation of vaccinated populations.

Incidence of Reactions

When vaccine is administered to children, the incidence of untoward reactions is low. Some vaccinees develop transient arthralgia or arthritis or an evanescent rash. Analysis of recent field experience indicates that these reactions occur more frequently after receipt of canine renal cell vaccine. To date, more than seven million children have received live attenuated rubella virus vaccine in public health programs in the United States. In addition, more than one million doses have been administered by practicing physicians. No serious adverse reactions attributable to the vaccine have been reported.

Vaccination of susceptible adult women is commonly associated with lymphadenopathy, arthral-

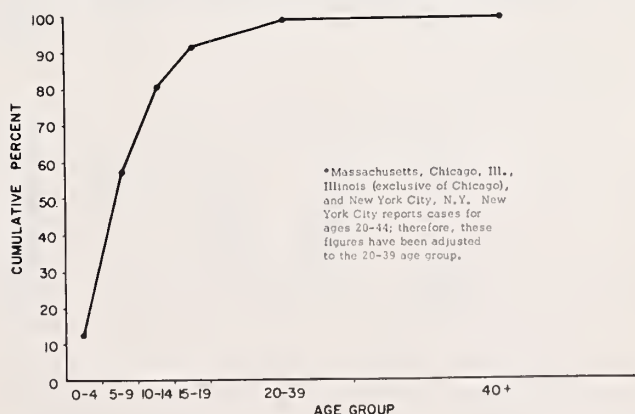
gia, and transient arthritis beginning two to four weeks after vaccination.¹⁰ However, fever, rash, and other symptoms of naturally acquired rubella have been reported less frequently. We do not know to what extent infection of the fetus might take place as a result of vaccination or whether damage to the fetus could result. Until further information is available, vaccination of pregnant women is contraindicated.

You must remember that in developing the rationale for the use of rubella vaccine, the prevention of infection of the fetus must be the principal objective of rubella control. This can best be achieved by eliminating the transmission of rubella virus among children, who are the major source of infection for pregnant women.

Vaccination Priorities

Since children in the 5-14 year age group are primarily responsible for the spread of rubella in the community, this group should be given the initial priority for vaccine. The Public Health Service Advisory Committee on Immunization Practices¹¹ as well as the American Academy of Pediatrics Committee on Infectious Diseases¹² currently recommend vaccine for boys and girls between the ages of

FIGURE 3
CUMULATIVE PERCENT OF RUBELLA CASES BY AGE GROUPS FROM SELECTED AREAS*—1963-1967



one year and puberty. Both committees, however, stress that the highest priority for vaccine should be given to children in kindergarten and the early grades of elementary school.

Routine immunization of adolescent girls and adult women particularly in public health programs should *not* be undertaken because of the danger of inadvertently administering vaccine before pregnancy becomes evident. Women of childbearing age may be considered, but only on an individual basis and only when the possibility of pregnancy for the succeeding two months is essentially nil. This cautious approach to vaccinating women of childbearing age is important for two reasons. First, there is a theoretical risk of administering vaccine to pregnant women because the teratogenic effect of the vaccine virus, if any, is not known at the present time. Second, it is known that congenital malformations occur in approximately 3 per cent of all live births. The fortuitous appearance of a totally unrelated malformation after vaccine administration could lead to serious misinterpretation.

If vaccination of an adult woman is contemplated, several steps are indicated. First, the woman should be tested for susceptibility to rubella. The rubella hemagglutination inhibition test (HI) antibody determination is particularly useful in evaluating immunity. It is a rapid, sensitive, and inexpensive procedure. Because of variation among reagents and technical procedures, results of serologic tests should be accepted only from laboratories of recognized competency that regularly perform these tests. Approximately 80 to 90 per cent of adult women will be immune. Immune persons can then be assured that vaccination is not necessary. Second, if susceptible, the patient should be vaccinated only if she understands that it is imperative that she not become pregnant for at least two months. To ensure this, a medically acceptable regimen of contraception should be followed. This precaution also applies to women in the postpartum period. Finally, the prospective vaccinee must also be informed of the relatively frequent occurrence of self-limited arthralgia and possible arthritis beginning two to four weeks after vaccination.

We have received a number of reports of women vaccinated in early pregnancy. In most cases, the immune status of the patient was not determined prior to vaccination. Many of these pregnancies were interrupted. Virologic and histologic studies of the products of conception are being carried out whenever possible. Preliminary data indicate that vaccine virus can occasionally be recovered from these materials; however, there are no substantive data to in-

dicating whether or not the vaccine virus can exert a teratogenic effect. None of the women who were vaccinated during early pregnancy and who did not have abortions have yet had their babies.

Emphasis on Children

In public health programs, the emphasis has been on vaccinating children. Most state and local health departments have focused their programs on children in the early grades of elementary school. However, many communities have been routinely giving rubella vaccine to preschool age children as well. By May 1, 1970, more than seven million doses of rubella vaccine have been administered in public health programs. The number should reach 10 million by the end of the school year in June, based on estimates of programs planned or in progress. Vaccine has also been given to children by private physicians. Although precise figures are not available, it is estimated that an additional two million children will have received vaccine from their physicians by June 30. By the end of June, 12 million children will have been vaccinated against rubella, which will substantially reduce the reservoir of children susceptible to rubella. We estimate that there are approximately 46 million children between the ages of one year and puberty in the United States. How many must be immunized to obviate future epidemics is not known. If the present rate of immunization continues through 1970, 20 million children will have received live attenuated rubella virus vaccine. The earliest that an epidemic would become evident is early 1971. By that time enough vaccine may have been given to significantly interrupt rubella virus transmission. Even if 1971 should be the next epidemic year, it is unlikely that the experience will be as severe as 1964. With a bit of luck and a lot of diligent effort, we may never have another major epidemic of rubella in the United States. In time, rubella and congenital rubella syndrome may become as rare as smallpox and poliomyelitis. Let us hope that time is not too far in the future.

Center for Disease Control 30333

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COMMUNICATION EVALUATION LABORATORY

Ponce de Leon Infirmary, Inc. announces the addition of a Communication Evaluation Laboratory to its Department of Audiology & Speech Pathology. The Laboratory will be used for diagnostic behavioral studies of very young children with suspected hearing, speech, or language disorders. The Center will continue to of-

fer diagnostic services in Audiology and referral services in speech pathology. Stanley J. Clegg (M.Ed, Emory, 1963) is chief of the department, and Mrs. Lynn H. Williams (M.Ed, Univ. of Ga., 1966) is part-time speech pathologist and assistant audiologist.

SOCIAL SECURITY DISABILITY "HANDBOOK" BEING DISTRIBUTED

Within the next few weeks all members of MAG, in active practice, will receive a recent printing of *Disability Evaluation Under Social Security—A Handbook for Physicians*. It is a very effective presentation of the medical evaluation criteria used by the Georgia Disability Determination Unit (a unit of Vocational Rehabili-

tation) and the Bureau of Disability Insurance to determine impairments as well as those general features of the disability benefit program. It is believed that physicians will find this *Handbook* of assistance in understanding the requirements of the Social Security Disability Program.

*"Either we shall master the ways
of political action, or we shall be
mastered by those who do."*

—Raymond Moley

JOIN
GAMPAC

The Responsibilities of a County Medical Society President

RONALD F. GALLOWAY, M.D., *Augusta*

ABOUT 18 MONTHS AGO I was fortunate enough to attend a meeting of County Medical Society Officers sponsored by the AMA in Chicago. It was interesting to me to hear the various terms used to describe the sizes of county medical societies. The term *large society* was used by many to describe the medical societies of several thousand members. On the other hand, the term *small* or *smaller* medical societies was used to describe societies of around five to six hundred members or less. I found this particularly interesting in that by this somewhat loose classification, the Fulton County Medical Society would almost be considered a medium-sized county medical society. As a matter of fact, I consider the Fulton County Medical Society as a large one. My own Richmond County Medical Society, which consists of about 280 members, would be quite small and many of your county medical societies composed of, say, 10 to 15 members, would be almost non-existent.

I am certain that there was no attempt by these members of larger societies to belittle our smaller societies. This comparison is simply to introduce the point which I would like to make as an opening statement for this afternoon's panel: Although the size of a county medical society may vary from several members to several thousand, the basic responsibilities of each county medical society President are the same. Admittedly, a society President will have far more responsibility in a society of several thousand than a society of eight to 10 members. However, each still has basic duties and certain basic responsibilities which are common to all medical society Presidents, regardless of society size.

Those of you who have served or are now serving as county society Presidents can appreciate what an honor this is and at the same time can appreciate the mixed feelings of loneliness, joy, fright, courage, awe and sense of duty which one feels when one first as-

sumes the office of President of a county medical society.

Presidential Roles

I suppose the President of a county medical society, as head of that organization, has three primary roles. One as a leader, one as an administrator, and one as a presiding officer. Each role calls for different abilities. However, there are certain fundamental qualities that all good county society leaders must have in common. One such quality is the ability to plan. That is, the ability to sense what the other members of the county society want and then the ability to help them crystalize their thoughts and ideas. Another quality is the ability to unite. That is, to rally members behind either your plan or their own plan and behind you as their leader. Perhaps the most important quality is the courage to win.

A good county medical society President works *with* his members and tries to keep them happy while they are working *with* him. He tries to have power *with* his members, not *over* his members. Carrying out the will and goals of a county society is a project in human collaboration which the President must lead.

A county medical society cannot be merely a group of doctors working toward any common aim. It must also be a powerful medium through which you and your fellow physicians can realize your individual hopes. A competent society President forges ahead towards the goal of the entire society, but he cannot be blind to the aims of its individual members.

A county society President must be a leader skilled at handling people, who can recognize that sentiment and tradition are important influences both in welding people together and in dividing them. This human understanding is a basic factor in good leadership, and can either make or break a county society President.

Presented at the 12th Annual MAG County Society Leadership Conference, Feb. 14-15, 1970, Atlanta.

Administrative Duties

Now, we spoke of the county society President as an administrator. The most important duties of a President of a county medical society as its administrator are to: (1) Act as its chief administrative officer and legal head of the county society; (2) Exercise supervision over the county society in all its activities; (3) Represent and speak for the organization to other organizations and to the public; (4) Preside at business meetings; (5) Appoint committees and committee chairmen; (6) Sign letters or documents necessary to carry out the will of the organization; and (7) Serve as Chairman of the Board of Directors, or other governing board of the society.

As the chief administrative officer and legal head of the organization, it will be your responsibility to administrate the bylaws of your organization and to judge how they shall be applied to situations as they arise. Many times, you will find that similar problems have arisen before and will then find that advice from previous Presidents will be helpful. However, each new President has his own new problems to arise, and must often decide for himself how these shall best be handled. In this capacity, a society President will find that application of the Golden Rule will be a valuable help. An active county medical society will have several activities proceeding at once. Each activity needs supervision not only by the particular chairman of the committee carrying out this particular activity, but by the President; for it is the President's responsibility to see that the county society's activities are in keeping with the basic purposes of the county society and with the standards of ethics of the county medical society, the state medical organization, and the American Medical Association. As a county medical society President you will be asked to represent your organization to other organizations and to the public. Here many of you will find, as I found, that being a county medical society President does not automatically qualify one as a public speaker. However, as you speak to various organizations you will quickly learn that their interest in how you present your material is far over-shadowed by their interest in what you have to say. To such organizations you represent not only a physician, but a leader in the community, and an expert on the affairs of health. As county medical society President you will be called on from time to time to comment on various newspaper articles and editorials. Rest assured that one year as county medical society President will develop you into an avid newspaper reader. I quickly learned that the small article which I merely scanned and did not consider important could very likely be the one which I would be asked to spontaneously comment on by tele-

phone. Rarely, and fortunately these occasions were rare, I would request permission of a reporter to re-search the article a little further and call him back. My research would then consist of finding that particular edition of the paper, reading the article closely, perhaps for the first time, and then quickly forming my thoughts as to not only how I felt about the article but how I felt that the majority of the members of my county society would react to the article. Obviously, in these situations, there is no time for any sort of poll or interview of the county medical society before responding to a newspaper inquiry. Here one needs to be able to sense the feeling of his fellow practitioners on particular matters. Sometimes this is easy, and sometimes it is extremely difficult.

Committee Responsibilities

The President must, of course, preside at all meetings of the county society. The particular responsibilities here I will go into in more detail shortly.

All committees must be appointed by the President. In a sizeable society of several hundred members, there will probably be a great many committees. In appointing your committee chairmen, there is a delicate balance between calling on those who have served faithfully in the same or similar capacity in previous years and calling upon those who are less familiar with the functions of that committee but who may have new ideas to bring into the society. No medical society President can appoint a large number of committee chairmen and expect each one to be a perfect committee chairman. So, do not expect to bat 1,000.

The amount of correspondence and paper work which a county medical society President has will vary considerably depending on the size of the society. During my own year as county medical society President, I quickly amassed a drawer full of carbon copies of letters to organizations, to fellow physicians, to lay persons, to senators and congressmen.

If your county medical society is large enough to have a Board of Directors, a Board of Trustees, or some other governing board, you, as the President of the society, will also serve as chairman of that board. Those of you who may have served in this capacity quickly realize that it is this governing board which has the prime responsibility of carrying out the multiple business duties and initiating the programs of the county medical society. Here most of the decisions are made and it is here that the President can best serve to see that the wishes of the county medical society are carried out in a way which will benefit medicine in the community and the county medical society as well.

Presiding Officer

As presiding officer, the President of the county society is the leader and representative of the entire society. Respect for his position is respect for the organization and for the members who have chosen him. Just as a judge exercises wide discretion in a court room, the presiding officer of the county society should exercise wide discretion in a meeting. He cannot be a robot limited to mechanical responses, but must meet each situation with flexibility of judgment, common sense, and fairness to all members, acting always impartially and in good faith during discussion of matters before the county society. The President has great latitude in carrying out his duties. He should assist members in exercising their rights and privileges and, if he knows facts that no other member can present, he should state them, in an unbiased manner. He should stimulate and encourage discussion and participation in matters before the society. He should see that all sides of a controversial question are presented by asking if members wish to discuss a different viewpoint, and by alternating the opportunity to speak between friends and foes of the question before the society. He should make sure that members understand all proposals and what their effect will be on the membership of the society. If members **DO NOT UNDERSTAND**, it is his duty to see that proper explanations are given. Presiding over the meeting of a county society cannot be learned from a book. The tactful President knows how to discourage courteously the member who talks too much or too often and how to encourage the shy member who speaks only when impelled by strong convictions. When an assembly is restless he knows how to shorten discussions and how to make business move along. Yet, he can also sense when members are confused and when the business should move more slowly. He *must* know parliamentary law, and how to apply it.

"Minor" Responsibilities

In addition to the responsibilities which I have

outlined here there are other so-called *minor* responsibilities which at times seem very major. A county medical society President may find himself serving in the role of a father confessor to a member who has somehow found himself in a difficult situation either professionally, morally, ethically or emotionally, and comes to the county medical society President for consolation and for advice. This may be a difficult role but is one in which a county society President can be of vital importance in serving his fellow physician. In this role, a medical society President will find that his own strong faith in God will see him through a difficult and perplexing problem laid on his lap by a fellow physician.

You will also find yourself serving as a sounding board for complaints not only from your fellow physicians but from lay persons in the community. Once I had completed my year as President, I found it interesting to look back and to realize that I had not found it necessary to refer a single complaint to the Grievance Committee of our society. Indeed, there were complaints and I heard my share of them. However, many complainers, whether they were physicians or lay persons, simply wanted someone to hear them out. Many times, merely by listening patiently for five to 10 minutes, I could readily understand and appreciate a problem, and advise the person as how best to settle the issue himself. Frequently, this took nothing more than advising a patient to contact his physician in order to straighten out a misunderstanding. In doing this, I always left the door open to call me back if matters did not work out. Perhaps I was extremely lucky, but in none of these situations did I feel impelled to pursue the matter further by referring it to the Grievance Committee for handling. This takes diplomacy, tact, and patience, but these three virtues can make your job as county medical society President a much easier one.

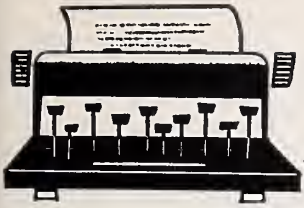
In closing, if I might give one single piece of advice to all of you who are now serving or will some day serve as President of your county medical society, I think it would be that excellent piece of advice from Mark Twain: "When in doubt, tell the truth."

1467 Harper Street

ANNUAL YAMPOLSKY LECTURESHIP

The Georgia Baptist Hospital's annual Joseph Yampolsky Honorary Lectureship will be held this year on Thursday, November 5, 1970 at 8:00 p.m. in the auditorium of the Georgia Baptist Hospital. The speaker

will be Samuel L. Katz, M.D., Professor and Chairman of the Dept. of Pediatrics, Duke University Medical Center, Durham, N.C. His subject will be "Slow Virus Infections and Their Implications for Pediatricians."



If You Don't Vote—Don't Gripe

Less than half of the registered voters in Georgia went to the polls on September 9 or on September 23 for the runoff.

IT'S PERHAPS DANGEROUS to generalize about people who do not exercise their basic responsibility to vote. However, when less than half of the registered voters avail themselves of the privilege it's probably worth the risk.

To the persistent non-voter, going to the polls on election day is an intolerable burden he would rather ignore. Having convinced himself that politics is dirty business, that government is unresponsive to his needs and that his participation in the process is so ineffective as to not make it worth the effort, he proceeds logically to what he imagines to be justifiable apathy and smug contempt for those who waste their time with such matters.

Precisely who should carry the "burden" of self-government is a question these people have never answered with much more than grade school logic. In a charitable moment we will concede that a few had a legitimate excuse for staying away from the polls. But charity must eventually give way to reason and it's probably both fair and accurate to say that most of them just didn't give a damn.

One can only speculate as to whether or not the non-voters are, in fact, the same group most vocally concerned about the ineptitude of local government and the ever expanding power of the Federal establishment at the expense of the States. It's a safe bet that they are one and the same group, making their apathy and concern all the more difficult to reconcile.

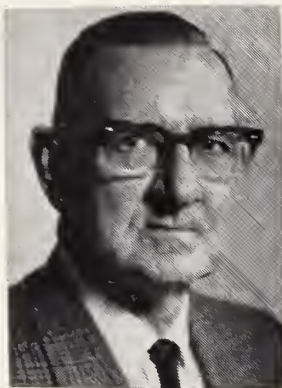
Obviously, the answer to the shortcomings of government at all levels begins at the ballot box, a fact so simple and so apparent that it's difficult to see how it could be overlooked.

JMAG, therefore, urges everyone—physician, wife, nurse, and indeed, the whole health team—to vote. November 3 is the big day. Don't assume for one second that someone else will do your job for you as you would do it for yourself.

24th ANNUAL AMA CLINICAL CONVENTION

Boston, Massachusetts

November 29-December 2, 1970



ABORTION: WHAT DO *YOU* THINK?

WHEN THIS LETTER IS PUBLISHED, each of you will have received a questionnaire regarding your opinion on induced abortion, and each of us who serve in any capacity on the Medical Association of Georgia Administrative Staff sincerely hope you took the few minutes required to indicate your personal feelings.

In the General Assembly Action of 1968, the laws governing abortion in the State of Georgia were modified and liberalized such that (1) Abortion is permitted to preserve the physical or mental health of the mother, (2) Abortion is permitted to prevent birth of a child with grave physical or mental defect or deformity, and (3) Abortion is permitted when pregnancy is a result of incest or rape. Residency requirements are in effect. Consultation with two qualified physicians is also required.

On August 24, 1970, in the case of Doe vs. Bolton, Civil Action # 13676 in the U.S. District Court of the Northern District of Georgia, Atlanta Division, the Federal Court found certain portions of Georgia Code 26-1202 to be in violation of the constitutional rights of the petitioner and as a result there is, in effect, a new Code 26-1202 in force.

The Court said: "In this respect, the State moreover has a legitimate interest in seeing to it that the decision (to abort), personal and medical, is not one undertaken lightly and without careful consideration of all relevant factors, whether they be emotional, economic, physiological, familial, or psychological."

This, in fact, means that should a woman request that her physician determine that she is pregnant, he has in fact accepted her as a patient, and that should she also request to be aborted, he could not refuse without being open to a charge of abandonment, unless he had a strict policy not to do therapeutic abortion on anyone. His policy and actions were to do *no* abortions whatsoever at any time.

Although our legal council has intimated that they felt a jury would not sustain such a claim, it would be possible to enter suit against a physician under the present Georgia statute as modified by the Three Judge Court described above.

There has been considerable difference of opinion regarding the actions of the House of Delegates of the American Medical Association in the most recent meeting of June, 1970. Listed herewith is the exact wording of the actions of the House of Delegates in June, 1970 for your information, and I would suggest that you keep a copy of this *Journal* for future reference.

AMA Position on Abortion

After lengthy hearings on a Board of Trustees report and five resolutions dealing with AMA policy on abortion, the House adopted the following substitute resolution:

"WHEREAS, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demand; and

"WHEREAS, the standards of sound clinical judgment, which, together with informed patient consent should be determinative according to merits of each individual case, therefore be it

"*Resolved*, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians chosen because of their professional competency and in conformance with standards of good medical practice and the Medical Practice Act of his State; and be it further

"*Resolved*, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles. In these circumstances good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

A third "resolved" stated that the American Medical Association will consider no physician to be in violation of the policies of the AMA as long as his practice conforms to the applicable State or Federal laws. This "resolved" was *stricken and not included*, and please *note* that it was stricken and not included.

The above stated action of the AMA House of Delegates deleted specific reasons for induced abortions such as (1) health, mental or physical type, of the mother, (2) rape, (3) incest, or (4) possible deformity of the fetus, but did not change basically the policy in general.

One of the opinions clearly stated in the 1967 Convention is as follows: "It is to be considered consistent with the principles of ethics of the American Medical Association for *physicians to provide information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion.*"

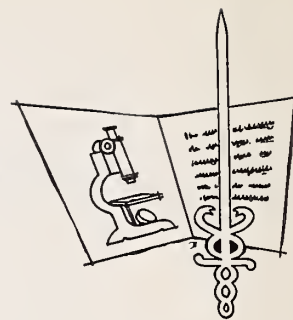
Legislation has been prepared and will be introduced in the General Assembly of Georgia this coming January concerning laws governing induced abortion, and it is hoped that each and every physician in Georgia will acquaint himself sufficiently to render aid to the legislators if they request such information from him.

The legal council of the Medical Association of Georgia will provide discussion and opinion for your guidance elsewhere in the Medical Association of Georgia *Journal*, so please retain copies of the *Journal* containing such information.

Sincerely yours,

A handwritten signature in dark ink, reading "F. G. Eldridge". The signature is fluid and cursive, with a long, sweeping horizontal stroke at the end.

F. G. Eldridge, M.D.
President, Medical Association of Georgia



QUALITY OF SURVIVAL—PART II

The Incurable Patient

JOHN PAGE WILSON, M.D., *Atlanta*

"The long habit of living indisposeth us for dying."

—Sir Thomas Browne

RECENTLY THERE HAS BEEN an organization of a group, some members of which are involved in the treatment of cancer, to study and consider the nature of death or thanatology (not to be equated with euthanasia). The problem of death is not new or exclusive to the physician, as anyone with school boy memories of Bryant's *Thanatopsis* can appreciate. But such emphasis delineates recognition on the part of many individuals that we must evaluate the nature of dying if the responsibilities to the patient are to be fulfilled.

Modern advances have enabled us to extend the physical circumstances of living farther and farther. The patient with incurable disease can often be kept "alive" for extended periods of time beyond what would normally be his demise with vigorous supportive care such as assisted respiration, blood and fluid administration and complete systemic alimentation.

It would be difficult to justify the extension for weeks of the painful, bed-ridden, incapacitating existence of the patient with hopeless, unrelenting carcinoma of the pancreas by heroic measures which, in themselves, are discomforting and debilitating as well as extremely costly. On the other hand, extension for a comfortable, useful and enjoyable few months of life can be worthwhile to the patient and the family, and a rewarding experience to the therapist.

Operative procedures have a very important place in the palliative care of the patient with incurable cancer. The general condition of the patient, the extent and location of disease and the expected course of the tumor may afford an opportunity for considerable benefit from surgery. Cancer of the colon, for example, frequently offers the chance by resection for relief from the distressing complications of obstruction, perforation and bleeding and a significant comfortable extension of life.

Radiation therapy will also, in the carefully selected patient, offer true palliation. The practitioner must be knowledgeable enough to avoid the debilitating effect of radiotherapy in the patient with an unresponsive tumor, in whom no reasonable chance of improvement is possible.

There is a place for chemotherapy in advanced disease; however, chemotherapy for the advanced solid tumor patient demands of the physician a full comprehension of all of the factors in its use. It demands evaluation of undesirable elements of such therapy, including the discomfort and disability involved, the occasional marked and distressing side effect of these drugs, the inconvenience and time lost in treatment and the significant financial demand. These and a realistic appraisal of the limitations of the actual extension of longevity must be weighed against the quality of survival.

The physician must be particularly cautious that "palliative" care is not used as an escape mechanism. There are many instances when solicitous concern and sympathetic interest are more palliative than exotic drug routines.

The medical profession as well as the individual physician whose responsibility is delivery of health care to the population of this country must seriously evaluate what comes under the heading of palliative therapy. It is extremely difficult to dissociate one's feelings from that of the patient from whom hope springs eternal, and one must acknowledge that Krebiozen as well as 5-Fluorouracil has evoked effusive positive psychological response from patients. The private practitioner, in particular, must consider with a great deal of circumspection investigational therapeutic programs which are expensive to the patient. Physicians who are involved in the treatment of the terminal cancer patient must make basic decisions of omission or commission in handling the patient terminally. Recent developments have made such decisions much more difficult and the implications much greater. A knowledgeable physician with wisdom and compassion is necessary for proper decisions.

340 Boulevard, N. E.

PRESCRIBE DEFENSIVELY FOR MOTORISTS

Physicians need to counsel patients when prescribing treatment that will impair their ability to drive. Otherwise, the physician may be partly at fault if the patient is involved in an accident.

64th Annual Meeting

Southern Medical Association

**Dallas Memorial Auditorium
Dallas, Texas
November 16-19, 1970**



CLINICAL USAGE OF THE NEWER DIURETIC AGENTS

V. M. BUCKALEW, JR., M.D., *Atlanta*

THE NEW ORAL DIURETICS which became available in the early sixties are among the most potent drugs in use today. The rational clinical application of these agents requires an understanding of their profound effects on renal function.

Most diuretic agents have been thought to act primarily in the proximal tubule. This seemed reasonable, since approximately 60-75 per cent of filtered sodium is reabsorbed in that segment of the nephron. However, recent research has shown that agents which inhibit sodium reabsorption only in the proximal tubule do not cause a significant natriuresis. This is due to the fact that sodium which escapes reabsorption proximally is reabsorbed almost quantitatively in more distal sites, primarily the loop of Henle. These considerations explain the fact that the two most potent natriuretic drugs available, ethacrynic acid and furosemide, exert their major effect in the loop of Henle. These agents can cause rapid excretion of up to 20-25 per cent of filtered sodium, and can therefore cause acute depletion of the extracellular fluid volume. The high rate of sodium delivery to the distal nephron caused by these agents stimulates the secretion of potassium and hydrogen ions and may lead to significant hypokalemia.

Agents which inhibit sodium reabsorption in the distal tubule have also recently become available. Spironolactone is a competitive inhibitor of aldosterone and acts on that fraction of distal sodium reabsorption which is under the influence of aldosterone, normally, 1-2 per cent of the filtered load. This fraction is significantly increased in some patients with edema, particularly those with hepatic cirrhosis. Triamterene inhibits a component of distal tubular sodium transport which is not dependent upon the effects of aldosterone. Again, this fraction is normally 1-2 per cent of filtered sodium but may increase in edematous patients. Both spironolactone and triamterene are most useful as natriuretic agents in combination with one of the potent loop of Henle blockers. They both decrease the excretion of potassium, which is useful in preventing potassium loss by the loop of Henle blockers. They can also be used in the treatment of severe hypokalemia due to renal potassium wasting. Hyperkalemia is a possible complication, especially in patients with impaired renal function, and these agents should not be given in combination with oral or parenteral potassium supplements, except during the correction of the most severe potassium depletion under hospital observation.

Onset of Action

An outstanding feature of the loop of Henle blockers is their rapidity of action. Given orally, they begin to have an effect in 30-60 minutes, with complete disappearance of the effect in two to four hours. This feature is a prime determinant of their safe and effective use. In order to give an amount of drug which will cause natriuresis and yet not cause acute volume depletion, it is necessary to determine the minimum effective dose (MED), which varies from patient to patient. In the majority of patients with normal renal function, the initial dose can safely be ad-

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

ministered as one tablet (40 mgm of furosemide or 50 mgm of ethacrynic acid). The patient should note an increase in urine flow within an hour after taking the pill. If this does not occur the dose was ineffective and should be increased by one-half or one tablet until the MED is reached. Most reasonably intelligent patients can make this adjustment themselves. There is no point in repeating an ineffective dose later in the day. For example, if one had a patient in whom the MED of furosemide were 80 mgm, it would be useless to give 40 mgm in the morning and 40 mgm in the evening. Although a total of 80 mgm would have been given, both doses would be below the MED and ineffective. Once the MED has been determined, a repeat dose can be administered if necessary. In my experience the MED of ethacrynic acid or furosemide in patients with significant renal failure is almost invariably two or three tablets, and sometimes more.

Triamterene is rapid in onset and is usually given in two divided doses of 100 mgm each. Spironolactone on the other hand may take 24-48 hours to exert an effect. Since it is a competitive inhibitor of aldosterone the effective dose will be directly proportional to the blood level of aldosterone. The usual starting dose is 100 mgm per day given in four divided doses; however, in patients with edema and hyperaldosteronism, much larger amounts may be necessary. Determination of the MED of spironolactone may require measurement of the patient's weight on a constant sodium intake or serial measurements of the daily urine sodium excretion.

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Accredited by the Joint Commission on Accreditation of Hospitals

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ATLANTA, GEORGIA 30308

Metropolitan Psychiatric Center, a private psychiatric hospital, provides individualized care for the treatment of emotional disorders. The Center is designed to provide the most functional and pleasant residential environment for psychiatric treatment. Central air conditioning, music in each room, and colorful furnishings provide a cheerful atmosphere conducive to rapid recovery.

The center is staffed by highly qualified psychiatrists and supported by a consultant staff of other medical specialists. Staff privileges are extended to all local psychiatrists who meet proper professional qualifications.

Additional information may be obtained by contacting the hospital by letter or telephone. Metropolitan Psychiatric Center is a member of The American Hospital Association, Georgia Hospital Association, National Association of Private Psychiatric Hospitals, and Metropolitan Atlanta Hospital Council.



GEORGIA ABORTION LAW UNCONSTITUTIONAL

JOHN L. MOORE, JR.,* *Atlanta*

ON AUGUST 24, 1970, in the case of *Doe v. Bolton*, Civil Action No. 13676, in the United States District Court for the Northern District of Georgia, Atlanta Division, the three-judge federal court found certain portions of the 1968 Georgia Abortion Law to be in violation of the constitutional rights of the petitioner. Following this Article is a copy of Georgia Code §§26-1201 and 26-1202 with the language held to be unconstitutional deleted. In effect, therefore, there is a new Code §26-1202 in force.

The court held that the state may not prescribe or unduly limit the reasons for an abortion. However, the court held that the quality of the decision as well as the manner of its execution are properly within the realm of state control.

The court held that a woman may not have an abortion on demand alone and that the state may legitimately require that the decision to terminate her pregnancy be one reached only upon consideration of more factors than the desires of the woman and her ability to find a willing physician. Further, the court held that the decision to abort cannot be considered a purely private one affecting only husband and wife, man and woman.

The court did not strike down the requirements for consultation with two physicians and approval by the abortion committee of a hospital nor the requirements for residency and proof thereof as well as filing certain documents with the State Department of Health.

The court said:

"In this respect, the state moreover has a legitimate interest in seeing to it that the decision [to abort]—personal and medical—is not one undertaken lightly and without careful consideration of all relevant factors, whether they be emotional, economic, psychological, familial or physical."

Until the decision above described of *Doe v. Bolton* is set aside by a higher court, it sets the law governing prosecutions under Georgia Code §26-1201 for criminal abortions. The decision also is determinative in private actions in Georgia.

It thus becomes essential to determine what duties are imposed under the present state of the law on: (1) the attending physician; (2) the two consultants required by §26-1202(b)(3); and (3) the abortion committee required under §26-1202(b)(5).

The Attending Physician

Under Code §26-1202(a) as changed by the three-judge federal court, an abortion may only be performed by a physician duly licensed to practice medicine and surgery in Georgia *based upon his best clinical judgment that an abortion is necessary*. The three-judge federal court did not give any definition of the word

* Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to The Medical Association of Georgia.

"necessary" but only struck the three reasons which the General Assembly of Georgia had specified as legal for the performance of abortions. The word "necessary," when read in the statute in light of the decision of the three-judge federal court, cannot be construed to mean necessary in order to save the life of the mother as the sole reason. It is clear from the opinion that the word "necessary" cannot be considered so liberally as to allow abortion on demand by the woman or simply upon request by the woman and her husband. A careful reading of the court's opinion would lead one to believe that the word "necessary" has a stricter meaning than the word "convenient." In considering the factors involved before rendering his best clinical judgment that an abortion is necessary, the attending physician should consider, among others, the following factors:

Has sufficient time elapsed since the discovery of pregnancy to indicate that the patient and her husband, if any, have thought the matter through carefully? Has there been discussion with and thought by the husband or other relevant family member or members, all of them having considered the emotional, economic, psychological, familial and physical factors? In the opinion of the attending physician, has the decision to request an abortion been reached on a proper balancing of those various factors?

The attending physician should be able to certify that there are no present medical contraindications not outweighed by the other considerations. This would include a consideration of the length of pregnancy prior to the suggested time of abortion. Possible guilt reactions after the abortion should be considered and related to the reasoning leading to the request for an abortion.

If, after satisfying himself that the decision has not been one undertaken lightly, but only after careful weighing of the emotional, economic, psychological, familial or physical factors, the physician should then certify only if he himself believes that the abortion is necessary in the sense above described.

Code §26-1202(b) remains in full force and effect and no abortion should be certified or performed by the attending physician unless he has received the residency certificate under oath and is able to certify that he believes the woman is a bona fide resident of Georgia and that he has no information which would lead him to believe otherwise.

The Consultants

The law still requires that two other duly licensed physicians certify in writing, based upon their separate personal medical examinations of the pregnant woman, that the abortion is, in their judgment, necessary. Therefore, the two consultants must make a separate personal medical examination of the pregnant woman and discuss the matter with her and her husband, if any, and review generally all of the matters discussed above under the heading "Attending Physician." The consultants should then certify, if they so believe, that the abortion is, in their judgment, necessary.

The Abortion Committee

The provision of the Georgia law requiring the performance of the abortion in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals remains. Further, requirement for approval in advance by the abortion committee of the staff of the hospital remains. The duties of the abortion committee no longer include the duty to restrict abortions to the three reasons earlier specified in §26-1202(a). However, the abortion committee should see to the following points. They should only approve an abortion if the file contains the proper documentation as to residency of the patient and the attending physician's statement with respect thereto. The abortion committee should see credible evidence in the file that the patient is pregnant. The abortion committee should be satisfied that careful consideration has been given to the factors described under the heading "Attending Physician" by the patient and the hus-

band, if any, and if reasonably available. If there is a husband and the husband is reasonably available, nothing in *Doe v. Bolton* disturbs the requirement for the written consent of the husband to the performance of the procedure. The abortion committee should only approve the abortion if it believes that the application satisfies the criteria of the statute as modified by the federal court. If the abortion committee, in its own judgment, does not believe that the abortion is necessary, considering the five factors described under the heading "Attending Physician," it may, and should, disapprove performance of the abortion. However, the abortion committee should not disapprove the abortion on the ground that it does not fit one of the three reasons specified in the Georgia statute before the court decision.

New Forms Suggested

The decision of the federal court requires revision of existing forms. A set of new forms prepared by Trammell Vickery, Esq., counsel to the Georgia Hospital Association, follows this article. There are no longer separate forms for abortion on the ground of rape as that portion of the statute has been stricken by the court.

CHAPTER 26-12. ABORTION

As Changed by the Decision Doe v. Bolton, August 24, 1970

26-1201. CRIMINAL ABORTION.—

Except as otherwise provided in section 26-1202, a person commits criminal abortion when he administers any medicine, drug or other substance whatever to any woman or when he uses any instrument or other means whatever upon any woman with intent to produce a miscarriage or abortion.

26-1202. EXCEPTION.—

(a) Section 26-1201 shall not apply to an abortion performed by a physician duly licensed to practice medicine and surgery pursuant to Chapter 84-9 or 84-12 of the Code of Georgia of 1933, as amended, based upon his best clinical judgment that an abortion is necessary.

(b) No abortion is authorized or shall be performed under this section unless each of the following conditions is met:

(1) The pregnant woman requesting the abortion certifies in writing under oath and subject to the penalties of false swearing to the physician who proposes to perform the abortion that she is a bona fide legal resident of the State of Georgia.

(2) The physician certifies that he believes the woman is a bona fide resident of this State and that he has no information which should lead him to believe otherwise.

(3) Such physician's judgment is reduced to writing and concurred in by at least two other physicians duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, who certify in writing that based upon their separate personal medical examinations of the pregnant woman, the abortion is, in their judgment, necessary.

(4) Such abortion is performed in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

(5) The performance of the abortion has been approved in advance by a committee of the medical staff of the hospital in which the operation is to be performed. This committee must be one established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals, and its approval must be by a majority vote of a membership of not less than three members of the hospital's staff; the physician proposing to perform the operation may not be counted as a member of the committee for this purpose.

(6) [Omitted]

(7) Such written opinions, statements, certificates, and concurrences are maintained in the permanent files of such hospital and are available at all reasonable times to the solicitor general of the judicial circuit in which the hospital is located.

(8) A copy of such written opinions, statements, certificates, and concurrences is filed with the Director of the Department of Public Health within 10 days after such operation is performed.

(9) All written opinions, statements, certificates, and concurrences filed and maintained pursuant to paragraphs (7) and (8) of this subsection shall be confidential records and shall not be made available for public inspection at any time.

(c) [Omitted]

(d) If an abortion is performed in compliance with this section, the death of the fetus shall not give rise to any claim for wrongful death.

(e) Nothing in this section shall require a hospital to admit any patient under the provisions hereof for the purpose of performing an abortion, nor shall any hospital be required to appoint a committee such as contemplated under subsection (b)(5). A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital in which an abortion has been authorized, who shall state in writing an objection to such abortion on moral or religious grounds shall not be required to participate in the medical procedures which will result in the abortion, and the refusal of any such person to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person.

26-1203. PUNISHMENT.—

A person convicted of criminal abortion shall be punished by imprisonment for not less than one nor more than 10 years.

PATIENT'S AFFIDAVIT

(To be executed *in duplicate* by the patient before performance of operation of abortion)

DATE TIME P.M.
A.M.

The undersigned patient, being first duly sworn, deposes and states as follows:

1. The undersigned patient has requested Dr. and assistants of his choice to perform upon her the operation of abortion.
2. The undersigned patient hereby certifies to the physician named above who proposes to perform the operation of abortion that she is a bona fide legal resident of the State of Georgia.
3. It has been explained to the undersigned patient, and she understands, that this operation is intended to result in the destruction of the fetus although this result has not been guaranteed. The undersigned patient has been informed by the physician above named of the nature of the operation to be performed, the risks involved, and the possibility of complications. The undersigned patient desires the performance of such operation, assumes the risks and consequences involved, and authorizes the performance of said operation at Hospital which is a hospital licensed by the State Board of Health, and accredited by the Joint Commission of Accreditation of Hospitals.
4. The undersigned patient hereby authorizes her physicians and the hospital above named to dispose of the fetus. The undersigned patient also authorizes retention, filing, and distribution of this statement as required by law.

.....
Patient

Personally appeared before the undersigned Notary Public (Name of Patient)

..... who, after being duly sworn, deposes and says that she has read and understands the foregoing Affidavit, and that the facts contained therein are true; and that she freely and voluntarily executes the same without coercion of any kind by any person.

.....
Notary Public

(STAMP AND SEAL)

CERTIFICATE OF PHYSICIAN TO PERFORM OPERATION OF ABORTION

(To be executed *in duplicate* before performance of operation of abortion)

DATE TIME A.M.
P.M.

The undersigned Medical Doctor, being a doctor of medicine duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, hereby certifies that:

1. The undersigned believes that (Name of Patient) is a bona fide resident of the State of Georgia. The undersigned certifies that he has no information which should lead him to believe otherwise.

2. The undersigned has made a personal medical examination of the patient and in his best clinical judgment, the performance of an operation of abortion is necessary. The factors upon which his judgment is based are summarized below and are further documented with reference to information contained in the patient's medical records which information is incorporated herein by reference.

.....
.....
.....

(Use additional sheets as needed and attach as supplement)

3. The operation of abortion is to be performed in Hospital which is a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

4. The undersigned has explained to the patient named above that the operation of abortion is intended to result in the destruction of the fetus although the result has not been guaranteed. The undersigned has informed the patient named above of the nature of the operation to be performed, the risks involved, and the possibility of complications.

5. The undersigned physician authorizes retention, filing, and distribution of this Certificate as required by law.

..... Physician Georgia License No.

Personally appeared before the undersigned Notary Public,, M.D., who, after being duly sworn, deposes and says that the facts stated in the foregoing Certificate are true; and that the opinion expressed therein he verily believes to be true.

..... Notary Public

(STAMP AND SEAL)

STATEMENT OF CONCURRENCE

(To be executed in duplicate by the concurring physicians before performance of operation of abortion)

DATE TIME A.M. P.M.

Each of the undersigned physicians, duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, certifies and states that:

- 1. He has made a separate personal medical examination of (Patient)
- 2. He has concluded that the said woman is pregnant, and has concluded that in his judgment the performance of an operation of abortion is necessary.
- 3. He believes that the patient understands the nature of her request and has requested an abortion with an understanding of the nature of the operation to be performed, the risks involved, and the possibility of complications.

..... Physician Georgia License No.

..... Physician Georgia License No.

CERTIFICATE OF ACTION OF ABORTION COMMITTEE OF HOSPITAL

DATE TIME A.M. P.M.

The undersigned physician, acting as (State Office) of the Committee of the Medical Staff of the Hospital located in, Georgia, certifies as follows:

1. The Committee is a Committee of the Medical Staff of the above hospital. The Committee is established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals.

2. At a valid meeting of such Committee held at o'clockM. on the day of, 197...., the performance of the operation of abortion on (Name of Patient) by (Name of Physician to Perform Operation) at (Name of Hospital)

..... was approved by a majority vote of the Committee membership of not less than three members of the Staff of the hospital. In computing the majority vote and the number of members of the Committee (Name of Physician to Perform Operation) was not counted as a member of the Committee.

..... (Physician)

John H. Venable, M.D.
Director, State Department of Public Health
47 Trinity Avenue, S.W.
Atlanta, Georgia 30334

Dear Sir:

As required by Section 26-1202(b) (8) of the Code of Georgia of 1933, as amended, we file with you the following documents relating to the performance of the operation of abortion upon (Name of Patient) which operation was performed at the hospital named below on (Insert date of Operation which must not be more than 10 days before the date of this letter):

1. The Statement of the Patient required by Section 26-1202(b)(1);
2. The Certificate of the Physician performing the operation of abortion concurred in by two other physicians as required by Section 26-1202(b) (2) and (3);
3. The Certificate of Action of the Committee of this hospital as required by Section 26-1202(b) (5).

I shall appreciate your acknowledging receipt of the enclosures so that our file will show complete compliance with the provisions of Georgia law.

Very truly yours,

..... Hospital

By

A fetal death certificate is required in all cases of abortion under a different Georgia Law (Section 88-1716). Information and forms may be obtained from the Georgia Department of Public Health.

*Suite 1220
C & S Bank Building*

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Hill Crest Foundation, Inc.

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THE ASSOCIATION



NEW MEMBERS

Andrews, H. Gibbs Active—Fulton—SU	1293 Peachtree St., N.E. Atlanta, Georgia 30309
Bailey, M. Thomas, Jr. Active—Fulton—I	3451 Peachtree Rd., N.E. Atlanta, Georgia 30326
Cooledge, John W. Active—Fulton—PD	3451 Peachtree Rd., N.E. Atlanta, Georgia 30326
Daly, Frank T., Jr. Active—DeKalb—R	755 Columbia Drive Decatur, Georgia 30030
Gregory, Arlene Active—Fulton—ANES	2550 Hargrove Rd., J-206 Smyrna, Georgia 30080
Hagen, Arthur R. Active—Glynn—OR	3010 Hampton Ave. Brunswick, Georgia 31522
Harbin, Bannester L., Jr. Active—Floyd—SU	Harbin Clinic Rome, Georgia 30161
Hoose, Kenneth A., Jr. Active—DeKalb—I	1276 McConnell Drive Decatur, Georgia 30033
Hyman, Barry N. Active—Fulton—OPH	401 Peachtree St., N.E. Atlanta, Georgia 30308
Lovejoy, John F., Jr. DE-2—Fulton—OR	300 Boulevard, N.E. Atlanta, Georgia 30312
Manning, Donald H. Active—Glynn—R	3010 Hampton Ave. Brunswick, Georgia 31520
McMillian, James R. Active—Floyd—PD	Harbin Clinic Rome, Georgia 30161
Mikell, Joel E. Active—Coweta—R	90 Jackson Street Newnan, Georgia 30263
Moran, Martin J. Active—Fulton—PD	275 Carpenter Drive, N.E. Atlanta, Georgia 30328
Moussakhani, Joseph Active—DeKalb—OBG	3041 Access Rd., N.E. Ex- pressway Chamblee, Georgia 30341
Newton, Z. B., Jr. Active—Fulton—OBG	735 Piedmont Ave., N.E. Atlanta, Georgia 30308
Ray, Walker L. Active—DeKalb—PD	341 W. Ponce de Leon Ave. Decatur, Georgia 30030
Routledge, James A. Active—Floyd—SU	310 W. Sixth Street Rome, Georgia 30161
Sanders, Steven L. Active—Fulton—SU	490 Peachtree St., N.E. Atlanta, Georgia 30308
Sciple, George W. Active—Fulton—P	2905 Peachtree Rd., N.E. Atlanta, Georgia 30305
Silver, William E. Active—Fulton—OTO	340 Boulevard, N.E. Atlanta, Georgia 30312

Taylor, Howard P. Active—Glynn—GP	Cottage 218 Sea Island, Georgia 31561
Wyatt, Thomas E. Active—Fulton—PD	1039 Ridge Ave., S.W. Atlanta, Georgia 30315
Zayas, Luis P. de Active—Clayton-Fayette— GP	117 Arrowhead Blvd. Jonesboro, Georgia 30236
Zimmerman, Mark J. Active—Fulton—OBG	340 Boulevard, N.E. Atlanta, Georgia 30312

PERSONALS

First District

Curtis G. Hames has been elected a director in the Atlanta-based holding company, Insurance Industries, Inc.

J. A. Heffernan spoke on the drug problem in Savannah at the annual meeting of the Business and Professional Women's Club of that city, in August.

Fifth District

James N. Brawner, III and **Alexis H. Davison** will serve as chairman and co-chairman, respectively, of the Medical Division of the United Appeal's fall campaign.

Michael B. Gravanis was named Professor and Chairman of the Department of Pathology, Emory University School of Medicine, in September.

Bernard S. Lipman was a guest lecturer in Minneapolis in September, at a symposium, "Acute Cardiovascular Conditions," sponsored by the Minnesota Heart Association and the Council on Clinical Cardiology of the American Heart Association.

Dan Burge has been installed as President, and **Harold W. Whiteman** as President-Elect, of the Georgia Heart Association.

Sixth District

Robert E. Cato and **Charles A. Duggan** have formed an association for the practice of diagnostic radiology in Macon.

Ninth District

Thomas L. Hodges, Jr., has received the American Medical Association's Physician Recognition Award in Continuing Medical Education. The award is designed to encourage and recognize those physicians who participate in continuing medical education.

Tenth District

A. D. Duggan and his son toured Africa during August and September. Dr. Duggan attended the Kenyan-American Symposium on Comprehensive Medicine in Nairobi, Kenya.

DEATHS

Jesse Bryan Brown, Jr.

Jesse Bryan Brown, Jr., 58, of Baxley, died August 30 in Appling General Hospital after a short illness.

A native of Emmanuel County, Dr. Brown had practiced medicine in Baxley for the past 23 years. He was a member of the First Baptist Church, had served as chairman of the City Board of Education, was chairman of the Appling County Board of Health, chief of staff at the Baxley Manor Nursing Home, member of the American and Southern Medical Associations, the American Academy of General Practice, the Medical Association of Georgia, and local medical societies.

Dr. Brown is survived by his widow, Mrs. Margie Lanier Brown; two sons, Jesse Bryan Brown, III, and Lanier Brown, both of Baxley; two sisters, Mrs. W. H. Carter of Powersville and Mrs. H. C. Bland of Portal, and a brother, Bernie H. Brown, of Garfield.

Anne McHenry Hopkins

Savannah's first woman physician, Anne McHenry Hopkins, died August 31 after a long illness. She was 71.

She attended Barnard College and received her M.D. degree from Columbia University College of Physicians and Surgeons. Dr. Hopkins interned and took her residency at the Massachusetts Memorial Hospital in Boston.

She began practice in Savannah in 1945, after being the physician for Simmons College in Boston for seven years. Dr. Hopkins was a pioneer in geriatrics in Savannah, doing advance study at the Endocrine Clinic, and was a staff member of the Savannah Tumor Clinic, Inc.

Dr. Hopkins was a former historian of the Georgia Medical Society, president of the Chatham-Savannah Health Council, and a co-founder of the Chatham Clinic for Alcoholism. She was member of the White Bluff Presbyterian Church and president of the women of the church, a member of the Society of Colonial Dames, and a member of the first troop of Girl Scouts of America organized by Mrs. Juliette Gordon Low.

She is survived by two sisters, Miss Katharine Lynah Hopkins and Mrs. Emma H. Hartridge, and several nieces and nephews.

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or

(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry
and Medical Director

Area Code 704-254-3201

Three Cases of Compound Comminuted Fracture of the Leg— Recovery Without Suppuration

Thomas R. Wright, M.D.,* *Augusta*

Prof. Billroth says, "The most successful operation never gave me such pleasure as the successful union of a severe complicated fracture." And this, I believe, but expresses the sentiment of every surgeon who has had many of this class of fractures to deal with. If we turn to the subject of complicated fractures in any surgical treatise, we find them classed among the most difficult and dangerous injuries to treat—difficult, because they require on the part of the surgeon good judgment, and no little skill in their management—and dangerous, because very often a limb and sometimes the life of a patient is in danger of being lost; if neither of these, they entail great suffering with exhaustive suppuration, and possibly necrosis or caries, with only a partially useful limb as a result. Such being the case, it is with pleasure I place on record the following cases, whose treatment and favorable results are given for what they may be worth.

CASE I.—On the 21st of August, 1879, I was called to see Robt. J., a negro man, about 50 years of age, who had received a severe injury of the right leg. Upon reaching him I found that he had been hurt by the falling of a heavy timber, 12 inches square, and 40 feet long—this timber catching his leg between it and another piece which was lying on the ground, thus making a kind of scissors joint, which had crushed the limb terribly. Examination of the leg showed a compound comminuted fracture of both bones at the junction of the lower and middle thirds, the bones being very much comminuted for a space of four inches, with a wound through the soft parts the size of a silver quarter, two inches above the external malleolus, from which the blood was flowing very freely, from the wounding of the peroneal artery. The foot, as the man lay on the floor, would lie flat, at right-angles to the limb on either side, showing that the parts had been terribly twisted. In fact, the man afterward told me, that as he fell his body twisted around on the crushed limb. At first sight of the case, I asked myself the question, shall I amputate or try and save the leg? I had seen amputations for less serious fractures, and I had also seen very serious compound comminuted fractures recover with very little trouble and *no suppuration*, upon just the treatment I would put this man upon if the attempt was made to save the limb. However, I sent for Prof. DeS. Ford in consultation, and after a careful examination of the injury he advised me to save the leg if possible.

Treatment

Accordingly, under ether, the limb was straightened out, extension and counter-extension made, and the fragments moulded as nearly as possible into position. A piece of adhesive plaster with a compress was placed over the wound, to control the bleeding if possible. The

limb was then placed in a fracture box and packed around with cotton, extension being made from the foot-piece; this constituted the entire dressing. Ten grains of sulph. quinine was ordered to be given at 6 p.m. At 6 p.m. I saw him again. The temperature was not taken; pulse 100. Bleeding had continued so that the compress was saturated, the blood trickling from beneath it. This was removed and a new compress dipped in cold tar-water applied. One-fourth grain sulph. of morphia was given, and 5 grains of quinine ordered given every four hours during the following day, commencing at 6 a.m.

August 22, 9 a.m. Temperature 100%, pulse 104; had slept very little during the night; blood still trickling from the wound. Compress again changed.

Six p.m. Temperature 102, pulse 118; at this visit it was found necessary, from the continued bleeding which had soiled the dressings, to change the box, which was done, the leg being placed in a clean box and packed with sawdust; quinine to be continued as before.

August 23, a.m. Temperature 101, pulse 110; had slept but little, and complains of severe pain in the ankle. Bleeding about as before. The hemorrhage now began to be a serious matter, and I feared the artery might have to be ligated; before doing this, I determined to adopt a suggestion of Dr. Ford's, and apply pressure along the course of the artery (peroneal) with a piece of rubber tubing laid over it, and firmly bound there by a many-tailed bandage. This was done and the bleeding ceased, giving no further trouble.

Six p.m. Temperature 102, pulse 112; no suppuration; quinine, 20 grains a day as before.

August 24, a.m. Temperature 99%, pulse 108; patient expresses himself as feeling very comfortable. No odor or pus.

Six p.m. Temperature 101, pulse 108; quinine continued.

August 25 a.m. Temperature 99%, pulse 100; no suppuration; patient doing well; 20 grains quinine, as before.

August 26 a.m. Temperature normal, pulse 92.

August 27 a.m. Temperature 100%, pulse 88, no suppuration. At this visit, the leg was placed in a plaster bandage, with paste-board side-splints, a fenestrum being left over the wound. As yet, no swell or suppuration.

Six p.m. Temperature 100%, pulse 76, says, "he feels well"; 20 grains quinine continued.

August 28, a.m. Temperature 99%, pulse 80; wound healing nicely, and with no suppuration. From this date, the record of temperature and pulse, ranging about normal, was not kept, and the quinine was reduced to 5 grains three times a day, and continued at that for a week, when it was again lessened to 10 grains a day, and continued for a week, and then left off. The patient continued to do well, and at the end of three weeks was allowed to sit up, the plaster bandage forming a

* Reprinted from the Transactions of the Medical Association of Georgia, 1881.

perfect support for the limb, the wound having healed without any suppuration. On the 1st of October, six weeks after the injury, the plaster bandage was removed, and union found to have taken place; a starch bandage supplemented with paste-board side-splints was then applied, and the patient allowed to go about on crutches. Twelve weeks after the injury this bandage was taken off, the bones being firmly united. The limb was not appreciably shortened—or, as he said, “his right leg used to be a little longer than his left, but now they were just right.” The ankle was a little stiff at first, but soon recovered its mobility, the man using his leg as though it had never been broken.

CASE II.—This case occurred in the practice of Dr. DeS. Ford, who kindly asked me to assist him in dressing, and who allowed me to keep the record. It will be referred to by the Doctor at another time. On the 2d of June, 1880, the Doctor was called to see G.W. (white), aged 45, a butcher and a hard drinker, who had received a compound comminuted fracture of the middle of the upper third of the left leg, by the kick of his horse—the shoe of the horse cutting through the soft parts, and comminuting the upper portion of the tibia; the fibula was not broken. The hemorrhage from the wound was considerable, but readily controlled by a compress and adhesive plaster. The leg was then placed in a fracture box and packed with wheat bran, extension being made from the foot-piece. We saw the case about four o'clock in the afternoon, he being under the influence of liquor at the time. At eight in the evening, when seen again, he was resting quietly; temperature 99, pulse 88; 10 grains sulph. quinine was then given, and 5 grains ordered given at six and eight o'clock in the morning, and at the same hours in the evening.

June 3, a.m. Had suffered no pain, and rested quietly during the night; temperature normal, pulse 84; quinine to be continued.

June 4. Continues to do well; no pain, smell, or pus; temperature normal, pulse 84.

June 5. Complains some of his knee, which was a little hot and swollen; no suppuration; temperature 99½, pulse 84; 20 grains quinine a day as before.

Six p.m. Temperature normal, pulse 85; knee feeling better.

June 6, a.m. Temperature 99½, pulse 84.

Six p.m. Temperature 99, pulse 84; no suppuration; quinine as before.

June 7. Temperature normal, pulse 82.

June 8. Normal temperature, pulse 84; wound in soft parts healed, and with no suppuration. From this date the record of temperature and pulse was not kept; the quinine lessened to 15 grains a day for a week and then discontinued, the patient getting along with no trouble whatever. On the 21st of June, three weeks after the injury, the leg was put up in a starch bandage with paste-board side-splints, the patient then being allowed to go about on crutches. He wore this dressing for a month, when it was removed by the Doctor, and firm union found to have taken place.

CASE III.—W.T., negro, aged 35. On the 11th of Nov., 1880, I was called to see this man, who had been injured by the falling of a heavy piece of machinery. On reaching him seven hours after the accident, I found a compound comminuted fracture of the right leg, at the junction of the middle and upper thirds. The limb was considerably swollen, and was bleeding freely from a wound of the soft parts, just over the fracture, on

the inner side of the leg. The wound was closed with adhesive plaster, and the limb placed in a fracture box and packed with saw-dust. Temperature at time of dressing (4½ p.m.), 101½, pulse 80; 5 grains quinine given at once and 5 grains at 8 p.m.

Nov. 12, a.m. Temperature 99½, pulse 68; some little blood oozing from the wound; limb still much swollen, with blebs forming around the seat of fracture. Five grains of quinine was ordered given at 6 and 8 a.m., but was not given until 9 a.m., after which 10 grains was given at 12 m., and 5 grains at 8 p.m.

Four p.m. Temperature 101½, pulse 104; still some bleeding; condition of the limb otherwise unchanged. Five grains quinine was ordered to be given at 6 and 8 o'clock morning and evening, and to be continued until further orders.

Nov. 13, a.m. Temperature 99½, pulse 98; removed the soiled saw-dust and put in fresh; the bleeding had ceased, but blebs were still forming.

Six p.m. Temperature 101½, pulse 104.

Nov. 14, a.m. Temperature 99½, pulse 100; he complains of pain under the fracture; and removing the saw-dust, it was found that a very large bleb had formed under the calf of his leg and broken, leaving a large ulcerated surface. I then placed the limb in side-splints, extending above the knee, leaving openings in the bandage over the original wound and the superficial ulcer. The whole dressing was then starched so as to keep it firm and stiff. The ulcerated surface was as large as the palm of the hand, and was probably caused as much by the crushing of the limb against the ground as by the breaking of the bleb. The ulcer was then dressed with carbolic acid and glycerine, 10 grains to the ounce, and the patient turned on his side; no suppuration from the wound.

Six p.m. Temperature 100, pulse 88; patient had turned on his back again, as he said the muscles of his thigh cramped when lying on his side.

Nov. 15, a.m. Temperature normal, pulse 88; ulcer dressed with carbolic acid and glycerine. As the patient could not lie on his side, and the pressure on the ulcer seemed to make it worse, I suspended the limb in a sling having an opening so that nothing could press upon the ulcerated surface.

Nov. 16, a.m. Temperature 99½, pulse 88; no suppuration, save a little from the ulcer, which was dressed as before.

Nov. 17, a.m. Temperature 100, pulse 100; same treatment continued.

Nov. 18. Temperature 99½, pulse 98; treatment as before.

Nov. 19. Temperature normal, pulse 88; no suppuration from the wound; ulcer dressed as before. From this date the record of temperature and pulse was not kept; the quinine being dropped to 15 grains a day, and continued for 10 days and then left off. The leg was kept in the sling for 10 days, at the end of which time both the wound and ulcer had healed; there being no suppuration from the wound over the fracture, and but very little from the ulcer.

On the 25th of Nov. the leg was taken from the sling and a roller bandage run up over the old dressing, the whole bandage being starched again. Five weeks after the accident, this dressing becoming loose it was taken off, and a new starch bandage with side-splints applied; this was worn for a month longer, and then removed, the patient having made a good recovery without suppuration.

THE MONTH IN WASHINGTON

The Nixon Administration is drafting legislation that would eliminate the reason for physicians forming professional corporations for federal income tax advantages.

The legislation would remove the tax discrimination against self-employed physicians and other professionals in the tax treatment of retirement savings.

K. Martin Worthy, chief counsel of the Internal Revenue Service, said the legislation probably will be submitted to Congress next year as an Administration measure. He said the Administration intends to "remove the present discrimination between tax treatment of qualified plans for employees and qualified plans adopted by self-employed persons."

Unfortunate Result

The IRS official said that it was unfortunate that disparate tax treatment of corporate employees and professionals has led to the adoption of state laws permitting the formation of professional corporations.

"The potential, if not actual, erosion of the traditional stringent professional standards and liabilities on the part of those who form such organizations is, in my opinion, a highly undesirable by-product of this problem and its resolution to date," he told a meeting of lawyers. "The intervention of a legal entity between the doctor, lawyer, or accountant and his client would not appear to serve any social or public purposes."

Warning

Worthy warned that recognition of a professional organization as a corporation for tax purposes did not

necessarily mean that the organization and its employees would have a clear track as far as securing the tax benefits which are desired.

Worthy said an important consideration to be weighed by the professional person is that the new tax act provides for a 50 per cent maximum tax rate, after a transition period, upon "earned income," which includes earnings from personal services.

"In view of this new tax ceiling, it is questionable whether a professional person would find it as important as it was previously to achieve the tax deferral available as an employee covered by a qualified pension or profit sharing plan," he said.

Relieve Shortage

The Board on Medicine of the National Academy of Sciences urged wide use of three types of physicians' assistants as the quickest way to relieve the national shortage of doctors.

In a special report, the board called for the cooperation of the American Medical Association, the Association of American Medical Colleges and the government in developing physicians' assistants programs.

AMA Backing

The AMA has been advocating use of physicians' assistants for some time. Dr. Walter C. Bornemeier, president of the AMA, recently said:

"We of the AMA believe the shortage (of physicians) can be dramatically relieved if the physician divests himself of functions which can be performed by assistants or associates. That relief would be provided, not in 10 years, but as fast as assistants could


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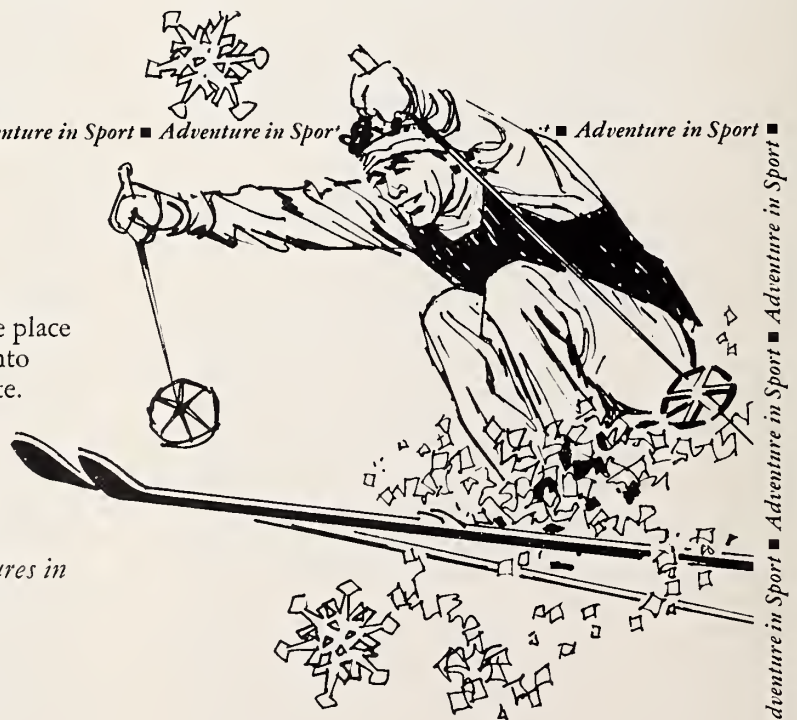
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be trained—no major legislation, no huge appropriations of money are required. We are certain the plan will result in better care for more people at a lower unit cost. Much of the training given to the assistants is, and would be in future programs, on-the-job instruction in the doctor's office.

"There is nothing revolutionary about this plan. Until 50 years ago, American doctors trained by working in the offices of established physicians. And even with the rise of university-affiliated medical colleges, we doctors continued to train the bulk of our non-professional nurses and office technicians."

The NAS board said that physicians' assistants could "extend the arms, legs and brains of the physician" by performing tasks that do not require the unique talents of the physician.

Types of Assistants

The three types of assistants recommended by the board were:

1) Physician's associate—the most highly trained type; would be qualified to do work that involves some independent medical judgment; under the physician's supervision, he could in some cases make a diagnosis and perform therapy, with the range of his responsibilities increasing as he develops new skills on the job.

2) Specialized assistant—would be highly skilled in one type of clinical specialty or procedure within a specialty (such as the operation of a renal dialysis unit); would receive most of his training from a physician specialist.

3) Non-specialized assistant—would be to medicine

what the practical nurse is to nursing; could receive much of his training on the job.

As the AMA has been doing, the board cautioned against the premature enactment of licensing laws that would establish rigid job qualifications before the full potential usefulness of the assistants had been determined. The board report recommended a system of registration that would permit physicians to employ assistants who had completed an approved program or otherwise established their qualifications.

Possession of a high school diploma should be an adequate prerequisite for training to become physicians' assistants, according to the NAS Board. It suggested varying amounts of education, clinical experience, and on-the-job training for the three types of assistants. For physicians' associates, it recommended the equivalent of two years of professional-level classroom and clinical work. Instruction should cover the basic sciences underlying medical practice, and clinical training should be "of essentially the same type and degree as that given medical students." Medical corpsmen, about 30,000 of whom are discharged from the military services each year, and other medical workers who enter the training program should be allowed credit for the clinical knowledge they already have acquired.

AMA Opposition

The American Medical Association opposed establishment of a national formulary that could restrict the prescribing practices of physicians with respect to federally supported medical programs.



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WASHINGTON / Continued

In a letter of Sen. Russell B. Long (D., La.), chairman of the Senate Finance Committee, which was considering such legislation, Dr. Ernest B. Howard, executive vice president of the AMA, said:

"The American Medical Association, representing approximately 180,000 active private practitioners of medicine in America, is opposed to a proposal that would interfere with the professional judgment and responsibilities of physicians. The proposed amendment, which would give a Federal Formulary Committee the authority to *exclude* from the Formulary (and therefore from payment) any drug which it considers unnecessary is, in our opinion, just such an infringement upon the professional judgment of practicing physicians.

Undesirable Authority

"The amendment would provide the Formulary Committee with authority to publish prescribing information about each drug listed. Adequate prescribing information to assist physicians in selecting the most rational course of therapy is available through a variety of acceptable sources. The proposed additional information is not only unnecessary but undesirable since physicians would be unable to deviate from that standard regardless of a particular patient's circumstances without facing the risk of malpractice liability.

"Further, the amendment would require that a physician who desires to prescribe the product of a particular manufacturer with which he had experience and confidence could do so only by writing in his own handwriting the established name of the drug again and the name of the preferred manufacturer. We disagree with this practice limiting the authority of the physician to prescribe the drug of his choice. Our governing body, the AMA House of Delegates, has stated and reaffirmed on many occasions that physicians should be free to use either the generic (established) or brand name in writing prescriptions.

Proposed Inspections

"In addition, the proposed amendment would have the Formulary Committee institute inspections, sample examinations and scientific review of drug products to be listed by the name of the supplier or the brand name. This task of the committee seems to be beyond its capability, particularly since it is constituted only on a part-time basis. . . .

"We have said many times that we want our patients to receive high-quality drugs at the lowest possible cost. We continue in this position, more strongly than ever. But, we firmly believe that the creation of a national formulary would not bring about a more economical provision of drugs under programs established within the Department of Health, Education, and Welfare, nor would it enhance the quality of these drugs."

Supports Bill

The American Medical Association supported a senate-approved bill that would expand federal family planning services and population research activities.

In a statement submitted to the House Subcommittee on Public Health and Welfare, the AMA said it believes the establishment of an Office of Population Af-

fairs under a deputy assistant secretary in the Department of Health, Education, and Welfare is highly desirable. The Office would make formula or special project grants relating to population and family planning; administer population and family planning research; act as a clearing house on domestic and international population family planning programs; provide liaison with other federal agencies; and support training for manpower in these programs.

Authorize Projects

The bill (S. 2108) also would authorize special projects for family planning services, formula grants for family planning, training and research grants, and grants for the construction and operation of population research centers.

The AMA said that there is an urgent need for a greatly expanded program of population research, as authorized by the legislation.

"If the worldwide population increase is to be controlled," the AMA said, "it will require more scientific knowledge of human behavior. We need more research on reproductive physiology, more demographic research, and more attitudinal and motivational research."

The AMA listed a number of obstacles to be overcome if a national program for population control is to be effective: education, religion, legal and economic considerations.

"The most formidable of these is lack of education," the AMA statement said. "Population control is only attainable when people first understand the nature of their own bodies."

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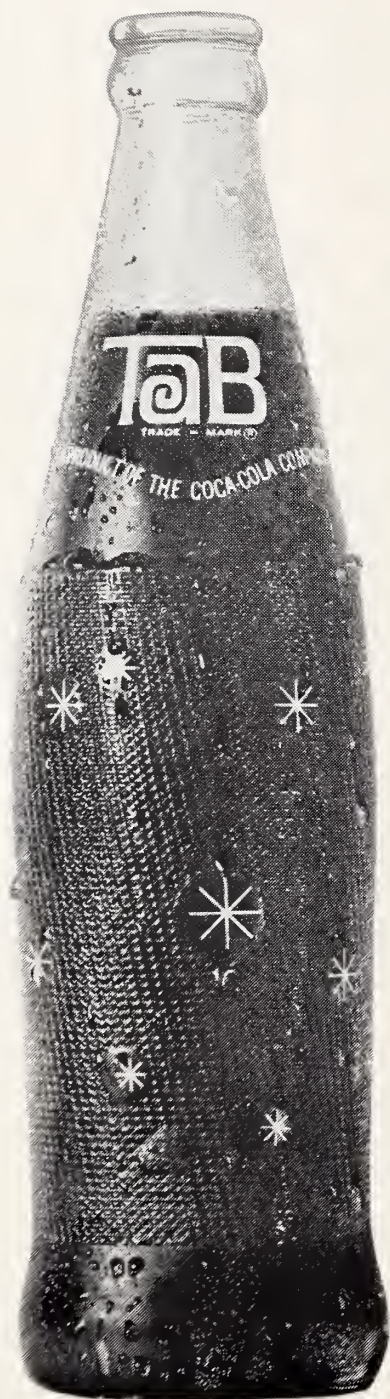
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Contents

Scientific Articles	
SURGICAL TREATMENT OF ABDOMINAL AORTIC ANEURYSMS Milton F. Bryant, M.D.	415
CLINICAL MANAGEMENT OF PATIENTS WITH PROSTHETIC VALVES Morton Korn, M.D.	418
Special Articles	
MEDICINE AND GOVERNMENT James W. Harkess, M.D.	420
RECENT DEVELOPMENTS IN THE STATUS OF WORKMEN'S COMPENSATION Tom S. Howell, Jr., M.D.	422
HEALTH STATISTICS USED IN "ERRATIC NUMBERS GAME" James Z. Appel, M.D.	424
Editorials	
PREVENTING DEATH IN A DITCH Carl Jelenko, III, M.D.	427
JABLONOWSKI NEW ADDITION TO MAG STAFF	428
Features	
President's Letter	429
Cancer Page	431
Heart Page	433
The Association	
New Members	435
Personals	435
Deaths	435

The aggressive approach of most surgeons toward these potentially lethal lesions is consistent with conservative management.

Surgical Treatment of Abdominal Aortic Aneurysms

MILTON F. BRYANT, M.D., *Atlanta*

BEFORE 1952 there was no satisfactory treatment for abdominal aortic aneurysms. It is interesting to quote from the popular textbook, *The Practice of Medicine*, edited by J. C. Meakins and published in 1950. "In the last analysis, apart from wiring the aneurysm and carrying out the general regime of rest and peace, but little can be done. The patient, however, should not be discouraged, as it is surprising how long he may live in comparative comfort, and the possibility of sudden exit from rupture should never be mentioned." The report of Dubost and his associates (resection and graft replacement) stimulated considerable interest in the United States. During the next few years many surgeons realized and experienced the advantage of treating these lesions by excision and graft replacement. Multiple large series of surgically treated patients have now been reported from various medical centers around the world. The reports of Szilagyi and associates,¹ DeBakey and associates,² and others^{3, 4} indicate that any patient with an abdominal aortic aneurysm should be operated upon provided he is a candidate for major surgery.

The first successful treatment of an abdominal aortic aneurysm in the state of Georgia was performed in 1954 by Akin and Harrison at St. Joseph's Infirmary in Atlanta. Bryant and Couves first excised a large abdominal aortic aneurysm at Piedmont Hospital in 1955. Aortic continuity was restored in both of these instances with a lyophilized aortic homograft. Since that time many surgeons throughout the state have successfully treated patients with abdominal aortic aneurysms.

Etiology

Most of the older textbooks list arteriosclerosis and syphilis as the usual cause of aortic aneurysms.

From a practical standpoint all of these "blow-outs" are caused by atherosclerosis. In order to be complete and thorough one must consider the possibility of syphilis and other infectious processes along with trauma as the occasional cause of an aortic aneurysm.

With atherosclerotic involvement of the wall of the aorta only two serious disturbances occur. First, one may have an accumulation of atherosclerotic material (frequently accompanied by overlying thrombus formation) which leads to atherosclerotic obstructive disease. Secondly, the atherosclerotic material may accumulate in such a fashion that degeneration and weakness of the structures in the wall of the aorta occurs. Subsequent ballooning and aneurysm formation may result. Most of the abdominal aortic aneurysms are fusiform in shape, although unequal dilatation may occur leading to a saccular appearance. The aneurysm may involve the terminal aorta alone or extend to involve one or both iliac arteries. Occasionally the aneurysm extends proximally to involve the renal arteries and the nearby visceral vessels. Fortunately, this does not frequently occur.

Pathologic Physiology

The main function of an artery is to act as a conduit for blood. Laplace⁵ originally described in mathematic terms the tension that is exerted upon the wall of a cylinder acting as a conduit for fluid under pressure. This law is expressed as follows: Tension = Pressure \times Radius. Simply stated, this means that the tension on the vessel wall is directly related to the blood pressure and the radius. Calculation reveals that the tension on the aortic wall is approximately 17,000 dynes/cm whereas the tension on the wall of a small artery or capillary is 15 dynes/cm. One can

easily see why acquired aneurysmal dilatation involves large arteries more frequently than small arteries. By the same token it is apparent why large aortic aneurysms are more prone to rupture than small aortic aneurysms. As will be brought out later, the principles of treating aortic aneurysms, whether they be conservative or radical, must take into consideration the law of Laplace.

Symptoms

Everyone is aware that both large and small aneurysms may be asymptomatic. The aneurysm produces symptoms by encroaching upon the surrounding structures. Involvement of the somatic nerves may produce vague discomfort to severe constant pain in the region of the aneurysm. Pain may radiate to the back, lower chest, groin or thigh regions. The vena cava may be compressed leading to edema of the legs. Rarely the aneurysm may rupture into the vena cava producing the typical symptoms associated with an A-V fistulae. Occasionally symptoms may be produced by compression of the duodenum and ureters.

Physical Findings

Usually one can demonstrate an expansile pulsatile mass along the course of the abdominal aorta. In corpulent individuals, or when the aneurysm is small, actual palpation of a mass may be difficult or impossible. A systolic murmur is usually heard over the aneurysm. At times the murmur is easier to hear in the left flank or lumbar region.

X-Ray Findings

Not infrequently, the diagnosis of an aortic aneurysm is first suggested by the radiologist. Tell-tale calcification, and mass formation, may be noted while performing a G.I. Series, I.V. pyelogram or routine lumbar spine x-rays. The most significant findings occur on the lateral film. A calcified curvilinear shadow located 5 cm. or more from the anterior surface of the lumbar vertebrae is diagnostic. We usually perform an aortogram to absolutely establish the diagnosis and to determine the extent of the lesion. This study can be performed using various techniques. In general we prefer translumbar aortography with high puncture of the aorta as it passes through the diaphragm. This technique is simple, safe and provides the needed information.

Associated Diseases

The possible occurrence of significant atherosclerosis at other sites must always be considered in any patient with an aortic aneurysm. Careful evaluation

of the coronary circulation must be carried out by an internist. The patient should be questioned regarding symptoms suggestive of cerebral vascular insufficiency. Significant murmurs may be heard over the carotid and vertebral arteries. Carotid and vertebral arteriograms may be needed and if severe segmental atherosclerotic stenotic lesions are found in the extracranial arteries, corrective vascular surgery should be performed before proceeding with direct surgery upon the aneurysm.

If hypertension is present one must consider the possibility of stenosis of one or both renal arteries as being the cause of the hypertension. Aortography will help establish the diagnosis. Separate renal vein renin studies may be needed to absolutely confirm the diagnosis of renovascular hypertension. Once the diagnosis is established the obstruction in the renal artery can be corrected at the time the aneurysm is resected.

Peripheral arteriosclerosis may encroach upon and obstruct the outflow tract in one or both legs. Arteriograms are essential in evaluating and planning the surgical approach when this problem is encountered.

The possibility of multiple diseases must always be considered in any elderly patient. Complete and careful study of these patients should be carried out before proceeding with the surgery. It does little good to resect an asymptomatic aneurysm in a patient who has an asymptomatic cancer.

Biologic Fate

Since Laplace's law continues to follow its course one can see that the biologic fate of an aneurysm is an incessant increase in size, finally leading to rupture. For this reason one must recommend surgical excision for any patient who is a candidate for major surgery.

Treatment

Most surgeons feel that all abdominal aneurysms should be resected if it is felt that the patient's general condition is such that he can tolerate major surgery. Some surgeons feel that small aneurysms—less than 5-6 cm in diameter—may be treated conservatively. This is particularly true in the extremely elderly patient and in patients who are in poor general condition where major surgery carries a high risk.

The history of the treatment of aneurysms is filled with many famous names. Proximal ligation, either partial or complete, resulted in many catastrophes. Various materials were used to ligate the aorta and no matter what technique or what material was used erosion of the aorta and fatal hemorrhage frequently occurred. In 1902 Rudolph Matas⁶ described his techniques of obliterative, restorative and

reconstructive endoaneurysmorrhaphy. While aneurysmorrhaphy was easily applied to peripheral aneurysms, it was difficult and not satisfactory for treating most abdominal aortic aneurysms. Pearse⁷ in 1940 developed the technique of wrapping the aneurysm with cellophane. It is doubtful that this technique helped many patients. Wylie⁸ proposed the use of fascia lata to wrap aneurysms in 1951. Recently Stallworth⁹ and his associates suggested using teflon to support the weakened and dilated aortic wall in certain selective cases. Blakemore¹⁰ and his associates in 1941 felt that these lesions could be treated by intraluminal wiring. Many aneurysms were treated by intraluminal wiring and coagulation; however, there is doubt as to how many patients were really helped by this procedure.

In 1952 Dubost¹¹ and his associates first resected an abdominal aortic aneurysm and restored aortic continuity with a preserved human aortic homograft. Surgeons interested in vascular surgery quickly saw the advantage of this mode of therapy and many series of patients were treated using the technique described by Dubost. Subsequently various plastic grafts (nylon, orlon, dacron, teflon) were developed. Today the most popular and satisfactory grafts are fabricated (knitted or woven) from dacron or teflon.

Creech¹² in 1956 showed that it was not necessary to completely resect the walls of the abdominal aneurysm. The aneurysm is frequently densely adherent to the surrounding structures and excision of the entire wall of the aneurysm is difficult and often dangerous. In removing the aneurysm the vena cava may be entered at multiple points with troublesome blood loss. Creech suggested that vascular clamps be placed proximal and distal to the aneurysm. The sac is then entered anteriorly and a modified endoaneurysmorrhaphy is carried out. Lumbar vessels are sutured from within the sac and aortic continuity is restored by suturing a teflon or dacron graft in place. The walls of the aneurysm are trimmed and then reapproximated over the graft. (This technique has been extremely helpful in treating these lesions and is the technique preferred by the author.)

After the aneurysm has been removed we feel that it is important to place some type of clip across the inferior vena cava. All of the available clips¹³ work well and the type used will vary with the preference of the surgeon. This simple maneuver prevents the occurrence of massive pulmonary embolism post-operatively and in my experience has not produced edema or any other complications.

Not infrequently the question arises as to what should be recommended for an 80-year-old patient with an abdominal aortic aneurysm. According to the Bureau of Vital Statistics, a male of age 80 can expect to live an average of 6.3 years. With this in

mind one would recommend surgical removal of the aneurysm if the patient is in good general condition. On the other hand if the aneurysm is less than 6 cm in size, or if the patient is not in good general condition, the surgeon might elect to treat and follow this patient conservatively. As is true with all surgical problems one must evaluate each individual patient and then use his best surgical judgment in recommending or not recommending surgery.

The present mortality rate associated with the surgical treatment of abdominal aortic aneurysm is less than 5 per cent and probably in the neighborhood of 2 per cent. It is known¹⁴ that approximately 50 per cent of patients with abdominal aneurysms treated conservatively will die within a period of three years—usually from rupture of the aneurysm. With these facts in mind one can understand the aggressive attitude of most surgeons toward these potentially lethal lesions.

1938 Peachtree Road, N.W.

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*These patients offer both challenge and
reward to the physician responsible
for their management.*

Clinical Management of Patients With Prosthetic Valves

MORTON KORN, M.D.,* *Miami Beach, Fla.*

REPLACEMENT OF DISEASED HEART VALVES has created a large population of patients with prosthetic valves. A prosthetic valve may be inserted in the mitral, tricuspid, or aortic position, or any combination of these. Artificial atrioventricular valves usually consist of a caged plastic disc or ball; the most commonly used mitral prosthetic valve in our institution is the Beall valve. The cloth-covered Starr-Edwards ball valve has become the most widely utilized aortic valve prosthesis. The clinical problems presented by patients with the varied types of prosthetic valves are similar.

General Considerations

The care of the patient with the prosthetic valve requires close, careful follow-up. It has been our practice to keep patients in the hospital for at least two weeks postoperatively. By this time there should be no residual problems relating to fever, infection, unrecognized leaks around the prosthesis, hemolysis, post-pericardiotomy symptoms, or anticoagulation. If the level of anticoagulation is adequate and the anticoagulant dosage has been stabilized, we recommend that the patient be seen one week after discharge. Thereafter, the patient should be seen monthly for the next six months. At six months we urge recatheterization of all patients with prosthetic valves. It has been our experience that most patients readily accept this and that a great deal of significant information can be obtained relevant to the function of the prosthesis, the presence of valvular insufficiency, and the state of myocardial contractility.

Patients with a prosthetic valve should be encouraged to live relatively normal lives. We urge our patients to resume their full activities over a six month period. Most patients appreciate general

guidelines for resumption of activity; occasional patients ask for day-to-day activity schedules. The basic guideline which we set is gradual progression of activity to limits of tolerance. A reasonable social and sexual life is encouraged. We discourage patients from smoking and using alcoholic beverages, the latter because of difficulty which may be encountered in maintenance of prothrombin time control. Our patients are usually urged to remain on a one gram (or less) sodium diet. We suggest that our patients inform their dentist of the presence of their prosthetic valve.

Specific Considerations

There are a number of important specific aspects which are involved in the day-to-day care of patients with prosthetic valves. First, each patient should have a thorough physical examination on each visit to his doctor. Great care must be paid to the quality of the prosthetic valve sounds. While it is beyond the scope of this paper to discuss the subtleties of prosthetic valve opening and closing sounds, suffice it to say that the physician should be aware of what any patient's prosthetic valve sounds like, and must be alerted by any changes which occur in these sounds. It also behooves the physician to be aware of any regurgitant murmurs suggesting a paravalvular or valvular leak.

It is usually necessary for these patients to utilize one of the cardiac glycosides. Many patients with prostheses are in atrial fibrillation and require glycosides for control of ventricular rate. With rare exceptions, we thus keep all of our patients on Digoxin, 0.25 to 0.5 mg. daily. Coincident with the use of digitalis the physician must determine the serum potassium level at frequent intervals. If the patient is receiving diuretic therapy, we encourage the use of potassium chloride supplementation. Dietary intake is usually insufficient to maintain normal serum potassium levels in most patients taking even small

* Chief, Section of Clinical Cardiology, Division of Cardiology, Mount Sinai Hospital of Greater Miami.
Prepared by the Georgia Heart Association for this Journal.

doses of diuretics. We supplement the diet with 10 ccs. of 10 per cent potassium chloride three times a day, or one ounce of the sugar-free potassium chloride solution (20 mEq) three times a day. Potassium chloride tablets should not be used. The incidence of digitalis intoxication will be reduced in relative proportion to the physician's ability to maintain an adequate serum potassium level.

We have adopted the principle of anticoagulating all patients with mitral and tricuspid prosthetic valves permanently. Formerly, we felt that a six month period of anticoagulation was adequate; however, we have recently encountered a sufficient number of late emboli even with the Beall valve to alter our policy. On the other hand, we are anticoagulating the patients with cloth-covered aortic prosthetic valves for six months only, unless an embolic episode occurs in which instance permanent anticoagulation is used. Patients who are on anticoagulants must be aware of the fact that the coagulation mechanism has been disturbed by the medication. Such patients must call to their physician's attention any problems of oozing or bleeding. Aspirin must be avoided. We encourage all patients on anticoagulants to look at their stools periodically and to report any darkening.

The use of rheumatic fever prophylaxis in patients with prosthetic valves is a controversial subject. Many groups discontinue routine prophylaxis at an arbitrary age, usually 21. We have elected to continue all of our patients with known or suspected rheumatic heart disease on daily penicillin therapy. Erythromycin is used in the patient who is allergic to penicillin. It is critical that the principles of subacute bacterial endocarditis prophylaxis be applied to any patient with a prosthetic valve who is to undergo a dental or surgical procedure. This cannot be over-emphasized. We have seen bacterial endocarditis in patients who were not on appropriate prophylactic antibiotic therapy before a minor dental procedure. Our policy has been to adhere to the

recommendations laid down by the American Heart Association.* For procedures involving the gastrointestinal and/or urinary tract, streptomycin is given in addition to penicillin.

It has been recently realized that all patients with prosthetic valves have some degree of hemolytic anemia. This is marked by elevated serum LDH, reticulocytosis and hemosiderinuria. Two problems may emerge in association with the hemolytic anemia. First, these patients may become iron deficient because of the loss of iron in the urine. Second, increased erythropoiesis exaggerates the daily requirement for folic acid. It has therefore been our policy to treat all patients with prosthetic valves with both iron and folic acid as long as there is any evidence of significant hemolytic anemia. Fortunately, serious hemolysis usually ends within six months, as the valve becomes endothelialized. The occasional patient will have need for intermittent packed cell transfusion over the first three to four months following valve insertion because of severe hemolytic anemia.

The final point worthy of emphasis concerns routine follow-up of all patients with prosthetic valves with an electrocardiogram and chest X-ray every six months. The electrocardiogram serves as an index of heart rhythm and rate, and calls attention to problems, such as digitalis intoxication, which can be missed clinically. The serial evaluation of heart size by chest X-ray is an important adjunct in evaluating the patient's progress.

The purpose of this paper has been to outline the general and specific therapeutic problems which may be encountered in management of the patient with a prosthetic heart valve.

Mount Sinai Hospital

* Management of Dental Problems in Patients with Cardiovascular Disease (EM 349); Prevention of Bacterial Endocarditis (EM 113B). Obtain from your Local Heart Association.

13th ANNUAL
MAG County Society Officers
Conference

February 6-7, 1971
Sheraton Biltmore Hotel,
Atlanta

The author's comments are of added significance since he has had first-hand contact with socialized medicine. He is a native of Edinburgh, Scotland, and received his medical degree from the University of Edinburgh.

Special Article

Medicine and Government

JAMES W. HARKESS, M.D.,* *Louisville, Ky.*

FEW WOULD DISAGREE that the health of the population is a prime objective of government. There are powerful lobbies, however, who contend that this responsibility would best be met by a National Health Service. Such diverse figures as Senator Edward Kennedy, Walter Reuther and Nelson Rockefeller are proposing programs which would place the medical profession under the control of a federal bureaucracy.

The proponents of such a system of medical care base their case on such statistics as infant mortality, the morbidity and mortality rates of the poor, and the high cost of medical care for everyone. These evils, it is said, result from the cupidity of a medical profession which has little compassion for those who pay and none for those who don't. During the last 10 years the physicians of America have been subjected to scurrilous attacks in newspapers, magazines and television in what seems to be a concerted effort to discredit them in the eyes of the public. Recently a singularly biased, highly partisan "Documentary" on CBS intimated that health was much too important to be left in the hands of the doctors, and that physicians, like generals, should be under civilian control.

Is this really true? Are we merely a collection of professional whores doing our thing for money? It seems to me that the causes of disease are primarily genetic and environmental. Of course, people living in overcrowded, substandard housing on inadequate diets will be sick. When children are spawned indiscriminately in the squalor of our slums by mothers too apathetic or too stupid to care, of course the infant mortality will be high! To be happy, all of us need a feeling of our own intrinsic worth—whether you call it pride, conceit or egoism is immaterial—

without it we are lost. It is difficult to acquire it as an untouchable in the lowest ranks of our society. He finds his illusion of power behind the wheel of a car, by having a gun or in a fifth of cheap booze. The poor vent their frustrations on the poor and violence is a way of life. But, is this our fault? When a house burns down do you blame the firemen who fought the fire or the arsonist who lit it? The poor are not poor because they are sick: they are sick because they are poor! It is not the failure of medicine but the failure of government that denies our slum-dwellers good health.

Socialized Medicine

In theory, socialized medicine will supply quality care to all at bargain rates; in fact, it does nothing of the sort. Costs are always substantially greater than estimates, economies must be made, and the quality of care suffers. Waste and inefficiency are inherent in any government service whether it be the Armed Forces, the Post Office or a Medical Service. Inevitably, services offered free are over-utilized, so that costs soar and some restraints must be applied. This was certainly true in Britain and in our own Medicaid program.

From the philosophical point of view, if you justify socializing medicine by saying that medical care is an essential for every American, then you must socialize the farms and supermarkets since it is just as essential that he eat. This line of reasoning taken to its logical conclusion is called Communism.

As a practical proposition, a National Health Service foisted on an unwilling profession is a poor idea. Most physicians in this country work long hours and make an honest effort to treat their patients as expeditiously as they can. Under a socialized system this urgency is lacking—it doesn't cost the patient anything to stay in the hospital and the doctor earns the same salary whether he works hard or not. I wonder if Mr. Reuther's plan will allow the physi-

* Chairman, Department of Orthopedic Surgery, University of Louisville School of Medicine. Presented at the 116th Annual Session, Medical Association of Georgia, May, 1970.

cian a 40-hour or even a 30-hour week and the right to strike for higher wages?

Quality of Care

We recruit our potential physicians from the intellectual cream of our youth. Once a career in medicine becomes less desirable the quality of physicians and medical care must inevitably fall. No matter what our detractors say, the quality of medicine in America is the best in the world.

However, this does not mean that everything is perfect. We do face serious problems which must be solved and in which our government must take a leading role.

Our production of physicians is not keeping up with our burgeoning population. Paradoxically, medical schools have been asked to expand the size of their classes while the government has taken away much of their financial support. Better methods must be found for educating physicians and, indeed, all health professionals to meet the ever-expanding needs of our population.

The sophistication of our modern methods require more personnel than ever before, so that the *per diem* cost in most hospitals has risen to unbelievable heights. In cases of catastrophic or long-term illness the resultant bill might well be beyond any individual's capacity to pay. Some mechanism must be found by which these costs can be substantially reduced.

Flaw in Reasoning

A flaw in the reasoning of many of the planners is the idea that the same type of medical care that is

appropriate for the rich is also the best for the poor. Nothing could be further from the truth. The poor need more care, longer hospitalizations and a host of ancillary services such as social workers, health educators and almoners which would be quite superfluous for the affluent. These unfortunate people need more supervision both in the hospital and at home.

Almost every large city has a large hospital whose duty it is to care for the indigent. By and large these institutions are monuments to the lack of concern local government feels for the poor. Most of them look like dilapidated dinosaurs. They are under-staffed and under-financed. Nevertheless, were they to be financed by government and administered by medical schools they would still be the optimum means of supplying excellent care to the poor.

The thing which most irritates me about the campus radicals is their assumption that they have invented altruism and that theirs is the first generation to be socially aware. My generation beat the drums for socialized medicine because we cared. My class was the first to graduate into the National Health Service and now, as a sadder and, I hope, wiser man, I don't believe this is the way to the medical millennium. The objectives of government and medicine are the same but we shall achieve them only as equal partners, not as master and slave. In securing every man's right to health, we should not abridge the even more fundamental rights guaranteed by our Constitution.

University of Louisville School of Medicine

COUNCIL ON KIDNEY AILMENTS FORMED BY HEART ASSOCIATION

A Council on the Kidney in Cardiovascular Disease has been established by the American Heart Association. A 350-member group, it has been functioning since 1962 as the Renal Section of the Association's Council on Circulation.

The chairman of the Council on Circulation, John W. Eckstein of the Department of Internal Medicine at the University of Iowa Hospitals in Iowa City, said in the memorandum to members that formation of the new Council was made possible "only because of the superb interest and work of the younger group of nephrologists who have given leadership to the Renal Section." He continued:

"Under the guidance of its previous chairman, Donald E. Oken (Cardiorenal Laboratory, Peter Bent Brigham Hospital), this group proved that there is a definite role in nephrology for the American Heart Association, particularly in the area of professional education and research. Also, the Association's role has

been defined as that of coordinating and cooperating with both the National Kidney Foundation and the American Society of Nephrology and there is no conflict of interests or duplication of efforts."

Roscoe R. Robinson, M.D., of the Department of Medicine at Duke University School of Medicine, Durham, North Carolina, was named chairman of the new Council, with John Boylan, M.D., of the Department of Medicine at Buffalo (N. Y.) General Hospital, vice chairman, posts both held in the Council on Circulation's Renal Section.

Nine other councils function within the framework of the American Heart Association as professional societies with subspecialty interests in the cardiovascular field. They cover arteriosclerosis, basic science, cardiovascular surgery, cerebrovascular disease, clinical cardiology, epidemiology, high blood pressure research, rheumatic fever and congenital heart disease, and cardiovascular nursing.

Recent Developments in the Status of Workmen's Compensation

TOM S. HOWELL, JR., M.D., *Atlanta*

FOR THE PAST SEVERAL YEARS members of the Medical Association of Georgia have been working with the Workmen's Compensation Board toward a better understanding of mutual problems. Based on this effort, and assisted by a recent court decision, a number of changes have been instituted. By the time this article is published each physician should have received information from the State Board of Workmen's Compensation explaining the present status. This information is best understood by a brief review of preceding events.

In 1953 a schedule of fees was suggested by physicians engaged in the treatment of industrial injuries; this schedule was approved by the Medical Association of Georgia and was adopted by the Workmen's Compensation Board. Interestingly enough, this schedule of fees was a "minimum" schedule and was introduced for the purpose of obtaining better medical care for the employee. This "minimum" scale required the employer, through the insurance carrier, to pay reasonable medical costs and discouraged attempts to secure "cut-rate" medical care. Over a period of subsequent years this suggested "minimum" has become recognized as "the" schedule. In 1968 the California Relative Value Studies was introduced utilizing a factor of 4.5; this, indeed, became the fixed fee schedule. The California Code was not designed to be utilized in this manner and such payments were inadequate. This was particularly true of many of the orthopedic and neurosurgical procedures.

On September 8, 1970 the Georgia Court of Appeals upheld a Superior Court ruling which stated that Workmen's Compensation fees "shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person." The literal interpretation of this statement is that fees shall be "usual and customary"; the State Board of Workmen's Compensation still

must approve the fees for services of physicians and hospitals.

Principal Change

The principal change introduced is that the physician is now instructed to submit his "usual and customary" charges for a procedure. In striving to establish uniform processing of claims, it is requested that all procedures be identified by the recently established A.M.A. "Current Procedural Terminology." It is also suggested that in those procedures where confusion may exist, the *code number* be supplied from the A.M.A. "Current Procedural Terminology." This code number is not a required factor; it is simply an aid for the non-medical personnel to identify procedures and process claims more efficiently. The Workmen's Compensation Board has again requested that the date of a patient's visits be recorded. This is considered an important aid in handling the payments as rapidly as possible. The present Workmen's Compensation Forms will continue to be used at this time; however, efforts are being made to obtain a more simplified form.

It is anticipated that in the majority of cases there will be no question regarding the physician's fee as "usual and customary." In the handling of complicated cases in which fees are questionable, the insurance company will submit all pertinent information to the State Board of Workmen's Compensation for review. A physician may also request the Compensation Board to review a case if he so desires. If, after evaluation of all factors and reports submitted, the medical fees or treatment cannot be adjusted to mutual satisfaction, the case will be submitted to the Medical Review and Negotiating Committee of the Medical Association of Georgia. The usual practice of this committee is to refer such questions to the appropriate County Medical Society, although determination will be made at the State level.

Both industry and insurance companies view these

changes with alarm; their contention is that medical fees will rise abruptly. I believe any physician who institutes a gross increase in fees is performing a disservice to himself and to the Medical Association of Georgia. Concern has been voiced regarding the computerization of fees and some individuals have suggested a raise so as not to be "caught" in a lower bracket. The Workmen's Compensation Board has given assurance that no such plan is anticipated. The final arbitration of complicated cases is determined by "peer review" of our state association;

with this procedure in effect, I trust that these fears are groundless.

Neither the Board of Workmen's Compensation nor members of the Medical Association of Georgia believe these recent changes to be a true panacea; however, it is a satisfying step in the right direction. The cooperation of all is needed—the physicians, the Medical Association of Georgia, the Workmen's Compensation Board—by all working together a mutually rewarding solution to most cases should be achieved.

663 West Peachtree St., N.E.

THE BLUE SHIELD ANNUAL PROGRAM CONFERENCE

John R. McCain, M.D., Atlanta

The Blue Shield Annual Program Conference was held in Chicago on October 5 and 6, 1970. The theme for the Conference was: "Stretching the Health Care Dollar," with the most interesting feature being the presentation of the economies in the cost of hospitalization available through Pre-Admission Peer Review. A paper on the subject was presented by Dr. James J. Schubert, Treasurer, Sacramento Medical Care Foundation. It is of special interest since preadmission certification of patients is one of the proposals included in the Bennett PSRO Amendment No. 851 of the HR 17550 bill in Congress.

The Pre-Admission Peer Review was developed by the Sacramento County Medical Society in cooperation with a private insurance company. The program is designated the Certified Hospital Admission Plan (CHAP), and includes 515 of the 700 physicians in the area. The program provides health care for 82,000 persons, with 77,000 qualified under Medicaid and 5,000 private patients.

CHAP is a program of prospective hospital utilization. The personnel involved in the administration of the plan consist of 60 medical advisors, with representation from each medical specialty. The plan has eight registered nurses who coordinate the activities in the 13 hospitals involved. The central office force consists of one additional nurse and two clerks. The program was summarized as follows:

Elective Admissions

As soon as the patient is scheduled for admission to the hospital the physician completes a simple form including the diagnosis and submits it to the central office. The diagnosis is then matched with developed standards for the length of hospitalization. A certification of fiscal responsibility is issued to the hospital guaranteeing the hospital payments. Each physician is assigned to one of the medical advisors for his CHAP review. Experience has permitted some physicians to be authorized automatic certification of patients for admission.

The certification of fiscal responsibility is based upon apparent medical need. If the physician decides to

admit the patient without a certification, he may do so, but the carrier then does not guarantee payment.

Emergency Admissions

The central office is notified as soon as feasible after an emergency admission, and may then immediately certify the admission and the standard length of the stay. The central office, if necessary, may request additional information from the physician and may refuse to certify the admission. If certification is refused, the physician has the right to appeal the decision through an established appeal mechanism.

Extension of Hospital Stay

If an extension of hospitalization is indicated by the patient's course, it may be obtained, when justified, without difficulty. The nurse coordinator monitors the duration of hospital stay in each hospital. The approval of the physician advisor must be obtained for all extensions of hospitalization.

Payment

Each bill submitted by the hospital must be accompanied by a stamped certification of the length of the hospital stay.

Economies

The length of the hospital stay was evaluated both before and after the CHAP was begun. If the evaluation is studied by disease categories, the length of the hospitalization was reduced by 23.6 per cent. If the study is made by the type of operative procedure, the length of hospital stay was reduced by 32.5 per cent. The shortened hospital stay resulted in a saving in the first 141 days of the plan of \$541,800 over what would have been anticipated by past experience. On an annual basis, the projected savings would be 1.4 million dollars for the hospitalization requirements of 82,000 persons enrolled in the program. The cost of the administration of CHAP is \$10.00 per hospital admission.

384 Peachtree St., N.E.

The criteria used in the gathering of statistics are frequently not comparable and this leads to erroneous conclusions.

Special Article

Health Statistics Used in “Erratic Numbers Game”

JAMES Z. APPEL, M.D.,* *Lancaster, Pa.*

AMERICAN MEDICINE is being harassed by an erratic sort of numbers game.

This “game,” sans referee, is played with vital statistics—the numerical charts and tables that help pinpoint health problems. But instead of applying statistics objectively to disease problems, certain critics are whetting them into weapons intended to discredit medicine as we know it.

Their chief barb is the contention: “America is not the healthiest nation on earth. Statistics prove American medicine to be inferior to that practiced in certain European countries.” The usual examples cited are England and Sweden.

Understandably, American physicians are not taking kindly to the goading. For if the international comparison of statistics shows anything, it can show that the opposite is probably true: that American medicine is second to none.

The divergence of opinion isn’t the fault of statistics. Rather, it’s the interpretation to which statistics are subjected after being wrenched from their intended use.

Poor Measurement

As a matter of fact, health statistics are a poor means of measuring one nation’s medicine with another. Those who are undoubtedly in the best position to judge—medical leaders from countries with the most favorable-appearing statistics—readily agree on this.

“The worth of statistical comparisons is overemphasized, to say the least,” according to Stanley S. B. Gilder, M.D., a British physician and executive editor of the *World Medical Journal*. “There is simply no correlation between health statistics of the United States and those of Europe. To argue statistics from one country to another is ridiculous.”

Nevertheless, the argument persists, augmented by material from the United Nation’s *Demographic Yearbook*—a telephone directory-size tome cataloguing the world’s population, birth rate, marital status and the manner in which people die.

Without doubt the *Demographic Yearbook* is the best archive of its type ever amassed. But it is not without drawbacks. Data collecting systems and reliability vary from country to country. Furthermore, events may be interpreted differently. What one nation lists as a live birth, another lists as a stillbirth. Some nations do not even include data on minority races living within their boundaries. For these reasons yearbook editors warn against the fallacy of jumping to unwarranted conclusions.

Fallacious Comparisons

Fallacy or not, comparisons are made, and on meager data. The charge that American medicine must take a back seat to foreign medicine most often is based on just two of the numerous tables in the yearbook. One denotes life expectancy; the other the infant mortality rate—the number of deaths among infants under one year compared with the number of live births.

Since the figures do show that in America the infant mortality rate is higher and life expectancy somewhat less than in England, Sweden and certain other small countries, this is offered as proof positive that we have inferior medicine.

On the surface it looks like a compelling argument, but perhaps only because so much is left unsaid.

No one wants to argue with the statistics themselves. The physicians who help bring babies into the world are certainly far from satisfied with our infant mortality rate. We have been and will continue to strive to lower it. So will Swedish and English physicians, who probably aren’t satisfied with their rates either.

* Former President, The American Medical Association.

But importing European practices isn't going to change our statistics one iota. Europe itself has already proven this. For example, although North Ireland and Scotland both adopted the English system of medicine, both are still worse off statistically than the United States. So, for that matter, are France, Italy and Germany, according to the *Demographic Yearbook*.

Incomparable Comparisons

The point is: comparing the vast melting pot that is the United States with the small, close-knit nations of Europe, may well be comparing the incomparable.

Waldo von Greyerz, M.D., Swedish delegate to the World Medical Association, thinks so. He has pointed out: "Sweden is a homogeneous nation, impossible to equate with the vastness of your country. The north and south of Sweden are virtually the same. Certainly this is not true in America.

"I don't know how you would compare medicine in Sweden, where we may be over-organized, with medicine in America. It surely can't be done with infant mortality and longevity statistics.

"People who do compare such things obviously are hunting for headlines."

It is, of course, a matter of record that Sweden's infant mortality rate is one percentage point below that of the United States and that the average Swede lives to age 73 and the average American to age 70.3.

But it is also a matter of record that a Swede in Minnesota outlives a Swede in Sweden, and, furthermore, that suicides occur with much more frequency in Sweden than in the United States.

But quoting such statistics proves what? Are we really gauging medicine or are we gauging something else?

The point is, no one knows, for the data can be applied in various areas.

Statistical Application

They can be applied in genetics, for example. Longevity is to some extent an inherited trait, and the extended life span of the Swedes may merely attest to this fact. As for the lower infant mortality rate, this may well demonstrate that genetically Swedes tend to be a large, robust people; and all else being equal, a woman of this type has a less complicated delivery than a smaller woman.

On the other hand, we can use the yearbook figures to show the possible effect of climate on life-span. We can show, for example, that while overall the average Englishman lives about half a year longer than the average American, those Americans living in a climatic belt roughly equivalent to En-

gland's live just as long . . . in fact, perhaps a little longer.

Furthermore, when you start comparing one nation's statistics with another's, it's not always certain that you're comparing exactly the same events.

To use Sweden again: a baby is not considered born alive there unless he actually breathes. In this country, if there is heart beat, movement of the voluntary muscles or pulsation of the umbilical cord, it is considered a live birth, whether or not the baby ever takes a breath.

Thus a child born with a beating heart but without the strength to breathe would be considered an infant mortality in the United States (a baby which was born alive and died). In Sweden, such a child would be listed as a stillbirth and not reflect on their infant mortality rate.

In some other nations, a baby is not legally born alive until his birth is registered with civil officials, or he is baptized—technicalities that might not take place for a week or so after birth.

Various Considerations

Nor is this all that has to be considered in arriving at a true picture of infant mortality, in contrast to a statistical picture.

There is the matter of foetal death rate, for example, which in England and Sweden is higher than here. From this a person with blind faith in statistics could conclude that American physicians are bringing babies into the world who would die in the womb in these other nations.

Also, it is difficult to talk about infant mortality without talking about abortion, which is legal in Sweden. There a defective fetus can be destroyed before birth, which has the effect of lowering the infant mortality rate.

Even if it were possible to shuffle and adjust infant mortality and longevity figures to take into account differences in genetics, climate, the law and reporting systems, it's still not certain whether you would have a yardstick for measuring medicine.

Greatest Progress

Certainly you can't gauge a nation's medicine without considering its medical progress. And no nation can match the United States in terms of progress.

The United States has made more important drug discoveries in the last 20 years than all the rest of the world combined—broad-spectrum antibiotics, steroids, tranquilizers and radioactive materials—not to mention all the other advances, such as measles and polio vaccines and open heart surgery.

Then too, consider that during the post-war years while we were constructing 763 new hospitals, England built one.

Whether in fact it is possible to come up with an international medical yardstick has not yet been determined, although the matter has been given study by the World Health Organization.

Causes of Death

One method, given some consideration, is the comparison of the causes of death. Such a reckoning would show the United States well ahead of any other nation.

Consider cancer. In the United States the death rate from cancer is well below that of any other Western nation. Since many cases of cancer are treatable, the lower death rate of the United States could be construed to mean that medical treatment in this country is better.

The same generally holds true for many other diseases—tuberculosis, pneumonia, strokes and influenza. All these are treatable to some degree, and all produce fewer deaths per capita in America than in Western Europe.

Undoubtedly these statistics, when used for international comparisons, suffer some of the same shortcomings as the infant mortality and longevity figures. But by ignoring these shortcomings—as do those who shape statistics into barbs against American medicine—the claim can be made that “America has the best medicine in the world.” It’s also possible to add, “Statistics prove it.”

Even the fact that the opposite holds true for death from heart disease—that our rate is higher than Western Europe’s—doesn’t necessarily refute this claim. For, the causes of heart disease are not well understood.

Economic Comparison

Diet and obesity may or may not be implicated. But there is enough evidence in support of this theory so that no nation-by-nation comparison of heart disease is possible without comparing diets also. And, when we start considering a nation’s food intake we’re no longer talking medicine. We’re talking economics.

We’re also, to a large extent, talking economics when it comes to automobile fatalities. Because Americans own more cars and drive more miles at greater speeds over congested highways, they die more frequently behind the wheel than Europeans. And these fatalities are a large factor in lowering our nation’s life expectancy.

In the same way that America’s economy blossoms into overweight, and auto deaths, so too do customs, environment, the pressures of making a living and factors such as educational levels have their effect on health.

Indeed, health statistics can be just as representative of a nation’s social patterns as its mode of medicine.

This is borne out by gerontologists (medical specialists in the problems of aging). Edward Bortz, M.D., past president of the American Geriatrics Society, has said again and again that Americans could live an average of 100 years if we’d just knuckle down to what we know is good for us and practice a little moderation. Instead, we go in for self-inflicted excess—too much alcohol, too much tobacco, too much caffeine and too many hours spent in an easy chair—all springing from habit, custom and our economy.

Understand Statistics

In dealing with any statistic, its basic nature must be understood. A statistic is a fact—the result of a survey—and that’s all it is. Conjectures made on such a statistic are not facts. They are conjectures.

Nevertheless, the assault by figures goes on as if there were no reality and no meaning except what can be wrung from this chart or that table.

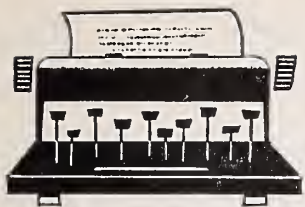
It seems to be a phenomenon of our time that all that is necessary to prove your point is to preface it with those magical words: “According to statistics. . . .”

Statistics, of course, are important. Used properly, they can lead to valid conclusions. Used improperly, however, they can “prove” any preconceived conclusion. The point is, statistics are a complement, not a substitute, for trained intellect and common sense. They pose questions, they don’t answer them. They are slaves, not masters.

1939 Pine Drive

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**November 29-
December 2, 1970
Boston, Massachusetts**



Preventing Death in a Ditch

FOUR AND ONE-HALF MILLION GEORGIANS need help in their fight to survive an epidemic disease! In Georgia, as in the rest of the United States today, the ravages attending motor vehicle accidents make this mode of death the fourth leading killer of our population. By any definition this is an epidemic. The physician not uncommonly finds that some of the carnage that follows an accident was preventable: some of the victims need *not* have died on the roadsides and in the ditches of Georgia if trained personnel had ministered to them at the scene of the accident, and if they had been transported in a vehicle fit for that purpose. These principles hold true regardless of the distance the patient must be moved, but become even more apparent as that distance lengthens.

Therefore, the accident itself may not always be the killer of our children, our friends, our neighbors. The accident may only set the stage upon which poorly trained or untrained personnel working with inadequate equipment and vehicles act to deliver their *coup de grace*. Throughout our state, various vehicles are currently operated under the name "ambulance," and all purport to be able to safely transport the sick and injured. In theory, at least, that's what an ambulance does. To do this properly, however, the vehicle must be manned by attendants who can do a competent job, outfitted with certain minimum equipment with which to face any emergency or contingency. All of this costs the owner or operator of the ambulance money.

Sometimes it seems that the service and humanitarian aspects of running an ambulance service, the need to provide well-equipped, safe vehicles, and the need to employ well trained attendants are all clouded by money: the costs of meeting these needs in terms of money, people, and hardware. It is certainly cheaper to operate at a marginal level—and more profitable if one charges a fee—than to maintain a true, worthy-of-the-name ambulance. It is also more likely to be lethal for the passive victim of the accident to be hauled off in a marginal vehicle!

An addition to the Georgia Health Code, Chapter 88-29, has been proposed which will help considerably toward improving the safety, reliability, and caliber of ambulance services in Georgia. This proposal, strongly supported by the Emergency Medical Services Committee of MAG, Executive Committee and Council, provides in essence that ambulances and ambulance attendants will have to meet certain minimum standards of safety and competence.

The provisions of the proposal are sound and they will work no hardship upon already competent ambulance services.

In Georgia today, ambulance services are rendered by a variety of individuals and groups. At times the operators accept personal hardships and losses to provide their valuable services to their communities. Many of these operators have a right to be proud of their services, and in many instances their communities would be lost without them. Under the proposed statute, the State Department of Public Health could assist weaker ambulance systems in efforts to upgrade their services. It cannot be argued that the upgrading of the only "ambulance" in an area works a hardship on that operator or area, or that it is a poor legislative concept!

It would seem that our course as concerned citizens is clear. We must, individually, urge our various legislators to vote for adoption of the proposed Ambulance Service Statute, Chapter 88-29 of the Georgia Health Code.

Your Association urges its adoption and the resultant reduction in epidemic—and unnecessary—deaths from accidents and injuries.

*Carl Jelenko, III, M.D.
Chairman, Emergency Medical Services Committee*

Jablonowski New Addition to MAG Staff



ADAM ROBERT JABLONOWSKI of Detroit, Michigan, became Assistant Director, Health Planning, for the Medical Association of Georgia on September 1, 1970.

The newly created staff position is designed to examine funding opportunities through the government and private organizations that would underwrite programs to be administered by MAG. This will include a Foundation for Medical Care concept, Health Maintenance Organization, Operation MEDIHC—Physician Assistants, Health Careers, Continuing Education and Member Economics.

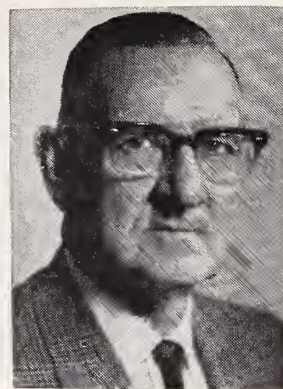
Born in Sokoly, Poland in 1944, Mr. Jablonowski came to the United States when he was four years old. He completed his college preparatory curriculum at the University of Detroit High School, and was graduated from the University of Detroit in 1965 with an A.B. degree in Psychology.

From 1965 to 1967, he served with the Peace Corps in India, working in public health and education. Upon returning to Detroit he taught in parochial schools on a substitute basis, later accepting a position as a high school English teacher.

Drafted into the Army in August of 1968, Mr. Jablonowski worked with the OCHAMPUS (Military Medicare) in Denver, Colorado until his discharge in August, 1970.

He has been the Soldier of the Month at Fitzsimons General Hospital in Denver, done graduate study in public and business administration at the University of Colorado, and served as graduate student representative for the University of Colorado, Denver Center Committee on Academic Progress.

Mr. Jablonowski is married to the former Linda Bertin of Garden City, Michigan. Now residing at 2235 Plaster Road, N.E., Atlanta, they are expecting the birth of their first child in November.



PRESIDENT'S LETTER

FROM OUT OF THE PAST—

THE EIGHTH DISTRICT MEDICAL SOCIETY held its semi-annual spring meeting in Jesup, Ga., in April of this year. An excellent program had been arranged and one of the visiting speakers was the recently appointed Dean of the Medical College of Georgia, Dr. Christopher C. Fordham. Dr. Fordham discussed several of his ideas regarding increase in the number of physicians in Georgia in general and localization of these physicians in the smaller communities in particular. In order to acquaint medical students of the senior class with the family practice of medicine and how to go about it, he posed a simple question, "How can I approach and present my ideas to the doctors in Georgia and thereby gain their support?" The answer to this question was obvious and he was invited to present these ideas to the Executive Committee of Council of the Medical Association of Georgia at their July meeting. Here he received immediate endorsement and was requested to meet with the full Council of the Medical Association of Georgia and again present his master plan. Again, he received unanimous and enthusiastic approval.

If the Georgia Academy of General Practice was the inspirational spark for this program, then certainly Dean Fordham along with Dean Robert Reynolds and a Faculty Curriculum Committee of the Medical College has been the catalyst. Their dedication to the program and their willingness to innovate and experiment with medical education has been a factor of prime consideration. The program will have a very modest beginning, but it is being organized on a solid base with every reason to believe that it will grow in size and stature. Initially, six senior medical students—preceptees—will select from a list of preceptors on file at the Medical College of Georgia. The preceptors, all members of the Georgia Academy of General Practice, have agreed to furnish the Medical College of Georgia with a mass of information concerning themselves such as their type of practice, the type and size of medical facilities available to them and many kindred facts and figures that will benefit the student in selecting his preceptor. The duration of the preceptorship will be one month and will be offered as an elective course for credit.

The student will become the preceptor's shadow, literally, joining him for hospital rounds, office hours and night calls, and as the physician preceptor pursues his daily practice in a routine fashion. The preceptee will also join the preceptor in his civic and family activities for his 30-day period and will see family practice as it really unfolds and not in the aura of a romanticized TV version.

In the early inception of the program, it was hoped that the Georgia Regional Medical Program could finance the project. However, this was not possible, even though the Director of the Regional Medical Program made every effort to do so.

PRESIDENT'S LETTER / Continued

This was not accepted as a setback by the Georgia Academy of General Practice Board of Directors, who immediately voted to obligate the Academy for requirements of this realistic program. The G.A.G.P. agreed to furnish transportation to the preceptee from the Medical College to the locality of the preceptorship, at which point the preceptor will take over and furnish board, room and laundry.

Many years ago, one of the earliest teaching methods consisted of a young boy "reading medicine" in the shadow and by the side of a practicing physician; it is ironic that at the time when our medical schools are experimenting with all manner of new approaches to the production of a greater number of physicians, this oldest teaching method should be re-instituted. Hence, from out of the past into the present and into the future may well be the re-institution of this preceptorship principle.

As for the practicing physician, the preceptor, this will not be an easy task; he will actually add to his burden, as it will take more time and effort in making this contribution for discussion and explanation to the student. Let it be said emphatically, the preceptor will not use the preceptee to work *for him* but *with him*.

So, a tip of the hat and hearty congratulations to both the dedicated general practitioner and the Medical College of Georgia personnel for their aggressive leadership so much in evidence in this program.


Sincerely,




F. G. Eldridge, M.D.
President, Medical Association of Georgia

Accidents will occur in the best-regulated families.
—Charles Dickens, *David Copperfield*

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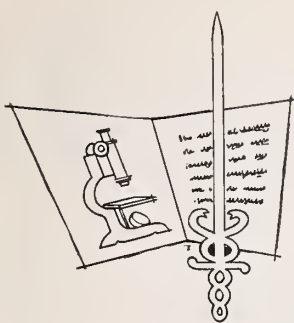


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ANGIOGRAPHY IN CANCER DETECTION

PANO A. LAMIS, M.D., F.A.C.S., *Atlanta*

ABDOMINAL ANGIOGRAPHY is now recognized as a useful procedure in the diagnostic evaluation of intra-abdominal disease. Refinement of the techniques over the last several years has now produced a standard percutaneous Seldinger method with its super-selective abilities permitting cannulation of all major and many minor divisions of the arterial supply of the abdominal organs. The procedure carries a low morbidity.

It frequently is of help to the surgeon in his preoperative evaluation and may allow for the confirmation of pathology in which suspicion was raised by the conventional radiological procedures, as well as reveal a disease process not otherwise detectable prior to surgery. This procedure has been of proven value in selective cases of acute gastrointestinal bleeding, in the diagnosis of portal hypertension, and in the evaluation of acute traumatic injuries of the liver and spleen. Its importance is well established in the detection of these non-oncological problems.

Angiography, however, is also playing an increasingly important role in the diagnosis of intra-abdominal tumors especially of the liver and pancreas. The angiographic diagnosis of these tumors is based on various signs such as displacement of vessels, irregular arterial stenosis, demonstration of newly formed pathologic vessels, accumulation of contrast medium in the tumor during the capillary phase, and early passage of contrast medium into the veins.

Opinions regarding the reliability of detecting carcinoma of the pancreas by this method have varied. Some recent studies, however, suggest that a significant degree of reliability in the diagnosis and exclusion of carcinoma of the pancreas may be obtained. A report from the University of Michigan Medical Center considered the angiographic abnormalities in each of 41 patients studied with carcinoma of the pancreas. They found the features to be diagnostic or strongly suggestive in 36 cases (88 per cent). The authors concluded that angiography, utilizing optimal technic, was a reliable method for the evaluation of carcinoma of the pancreas and they encouraged its use as a routine preoperative procedure. Another study of pancreatic carcinoma from the University of Chicago found abnormal angiographic examinations in 12 of 21 cases (57 per cent). Their method of choice for the diagnosis of early stages of pancreatic cancer was simultaneous selective visualization of the celiac and mesenteric arteries.

Primary liver tumors are, as a rule, highly vascular and therefore easily demonstrated by angiography. In a report from Sweden, 11 patients with hepatoma examined with hepatic angiography all had an abnormal vascular supply. Metastatic lesions to the liver may also be detected. The angiographic pathology of liver metastasis varies and is largely dependent on the type of primary tumor and the local spread within the liver. In cases of highly vascularized metastasis, very small

lesions may be demonstrated. These findings may be of considerable value in determining operability and prognosis. In chemotherapy of neoplasms of the liver by the prolonged infusion method, selective celiac and superior mesenteric angiography is a prerequisite to the surgical implantation of the catheters used for the perfusion, since the arterial supply to the liver must be accurately defined.

Angiography of the abdominal vasculature is proving to be of great diagnostic value. It can be anticipated that with increased experience the reliability of this technique will improve. All physicians should be familiar with the progress in the field of angiography and should utilize this method of cancer detection when indicated.

340 Boulevard, N.E.

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HYPERTENSION: AN OLD CHALLENGE WITH NEW OPPORTUNITY

THOMAS D. JOHNSON, M.D., *Albany*

A GROWING SENSE OF RESPONSIBILITY exists among physicians in Georgia for the treatment of the large number of young to middle-aged persons with hypertension. This is proper when one reflects on certain established facts: (1) there is a statistical increase of mortality and a shorter average life expectancy among those with even mild blood pressure elevations; (2) hypertension doubles the risk of coronary thrombosis or coronary insufficiency; and (3) blood pressure reduction by treatment of moderate and severe hypertension clearly can prevent stroke, and cardiac or renal failure. Those who argue against the treatment of mild to moderate hypertension in the asymptomatic individual contend that little can be accomplished by treating the mildly hypertensive individual, and that we too often render asymptomatic persons symptomatic through overtreatment. The data from a recent Veterans Administration study offers a challenge to these concepts. In this study the risk of a morbid complicating event (such as stroke, cardiac failure, or dissecting aneurysm) over a five year period in 380 male hypertensive patients with diastolic blood pressure levels averaging 90 to 114 was reduced from 55 per cent to 18 per cent by treatment. The investigators used hydrochlorothiazide, reserpine, and hydralazine in varying combinations. The effectiveness was clearest with the higher pressure levels, and it was most notable in the older individual. Treatment was most effective in preventing hypertensive complications and least effective in preventing atherosclerotic complications. The data strongly supports the value of treatment in the milder ranges of hypertension and emphasizes the substantial risk over five years of withholding modern drug treatment for hypertension. The challenge is compounded by epidemiological observations showing that one-half of persons with hypertension are unaware of it, that only one-half of those who know receive treatment, and that no more than 15-25 per cent continue the treatment once started.

The value of treatment does not reduce the need to search for curable forms of hypertension. We do, however, recognize that some patients once hopefully considered curable by surgery for renovascular hypertension are now better treated medically. We further recognize that the screening tests to uncover adrenal tumors have a disappointingly low yield for the practicing physician. Perhaps we can develop newer and simpler sorting techniques to obviate the intensive study not needed by the majority of patients with "essential" hypertension. It is also true that an aggressive treatment program can produce a distressing number of side effects. Our eagerness to achieve a quick result should not diminish the requirement for the careful monitoring necessary to avoid overtreatment, nor eliminate the use of mild medications with few side effects in the initial therapeutic trial.

Clearly some new approaches to patient detection, education, and treatment are needed. The adult population must be educated concerning the potential disa-

bility and mortality of untreated hypertension. We must overcome the lay myth that hypertension is a temporary state. We must promote the idea that for most hypertensive individuals treatment should continue indefinitely and that the danger is not in acute pressure elevation but in the slow development of vascular disease. Several aspects of the delivery of health care to the hypertensive should be studied including: (a) the organized use of paramedical personnel for the monitoring of hypertensive patients, and (b) the development of community blood screening clinics. A Georgia Heart Association committee on hypertension is working to develop a plan for meeting the challenge of hypertension. An oriented and interested medical community is necessary for success in this endeavor.

910 N. Jefferson

*The daughter of limb-relaxing Bacchus and limb-relaxing Aphrodite is limb-relaxing
gout.*
—Hedylus



for psychiatric treatment

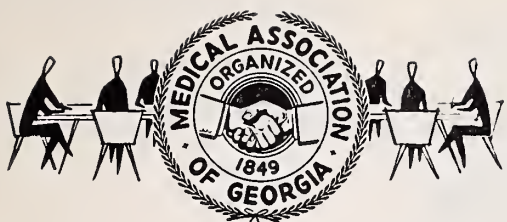
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PERSONALS

First District

Curtis Hames toured Norway and the Soviet Union in September, speaking on "Hereditary Aspects of Heart Disease" at the University of Oslo and examining medical facilities in Moscow and Leningrad.

Fifth District

Robert C. Garner is the new chairman of the Medical Advisory Board of the Fulton-DeKalb-Clayton March of Dimes chapter.

Bruce Logue gave a series of talks for the Palm Beach Area Heart Association in West Palm Beach, Boca Raton and Lake Worth, in October.

Alfred Messer was a featured speaker at the annual conference of the Georgia Association of Young Children held in Atlanta in October.

DEATHS

Emory Glenwood Newsome

Emory Glenwood Newsome of Sandersville died September 15 in an Atlanta hospital. He was 60 years old.

A graduate of the University of Georgia and the Medical College of Georgia, he had been in private practice in Washington County since 1939. Dr. Newsome was a member of Hamilton Masonic Lodge 58, F&AM, Washington County Medical Society, Medical Association of Georgia and the First Baptist Church of Sandersville.

Dr. Newsome is survived by his widow, the former Barbara Chambers; son, Emory G. Newsome, Jr., Dahlonega; daughter, Mrs. Julian D. Nealy, Atlanta; brother, W. E. Newsome, Sandersville; and sister, Mrs. Twiggs Tanner, Sandersville.



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CASE OF CUT THROAT—ATTEMPTED SUICIDE

Thomas H. Kenan, M.D.,* *Milledgeville*

I was called to see Mr. E.T.B., age 70—a case of suicidal mania—who had seized a razor from the bureau drawer as he arose from the chair in the shaving-room, on Sept. 22d, 1880. His attendant was at his side and caught him as he made the cut, the first incision only cutting the skin over the anterior portion of the left sterno-cleido-mastoid muscle, about opposite the angle of the jaw bone. In the scuffle he succeeded in passing the razor in on the left side (almost in the first incision), severing the anterior fibres of the sterno-cleido-mastoid muscle and external carotid artery—passing just under the cornu of the hyoid bone, cutting from one tonsil across to the other—severing everything—and coming out on the right side near the sterno-cleido-mastoid muscle. He was sitting up, head inclined forward, and supported to prevent strangulation, as the blood flowed freely.

I felt that he would die, in spite of all efforts to save him. Passing my hand in to brush away the clots, I found the fingers could pass up into the mouth. I brushed a heavy coating of Monsel's solution over the cut surface rapidly; and, again, hurriedly cleared away the newly-formed clots, to re-apply the solution. The ice having been brought, I applied a piece about the size and shape of an axe-blade within the cut, and pressed the head firmly down upon it (as the chin was held steady, thereby getting the effects of cold and pressure to the bleeding vessels), while Dr. Whitaker arranged to give brandy hypodermically. The radial pulse was suspended, and the surface cold. So soon as the bleeding ceased, he was covered up well, about two ounces of brandy in all being given hypodermically; and in a short time he rallied sufficiently to encourage us in the hope of getting him through the dangers of the immediate loss of blood.

To make a long story short, he had no more loss of blood. Ice and ice-cold watered cloths were kept constantly applied. The following day reaction was established, the wound well glazed, and he was fed by an improvised stomach pump. I used one of the best soft catheters, No. 14, on the end of a Davidson's syringe (using the child's nozzle), passing it over the cut (across the tongue), and pumped milk, beef-tea and coffee three times a day into the esophagus—asking him not to breathe while pressure was made upon the syringe, for obvious reasons. The parts remained in position very well so long as the chin was kept down, but when he coughed the sputa ran through the wound and the thyroid cartilage would play up and down in the effort of deglutition. The hyoid bone was uninjured; as before stated, the cut was between the hyoid bone and thyroid cartilage, separating them entirely. If you will remember that the head was thrown back and the neck upon the stretch, the razor going in point foremost, you can readily understand the nature of the injury.

What was to be done with so formidable a wound, was perplexing. The indications were plain, to be sure, but the delusions of the patient, the contending forces of the muscles and the impossibility of keeping the head and chin drawn down, made it a case of great anxiety to us. Dr. W. H. Hall (of the Board of Trustees) met us in consultation. A few stitches were taken, the chin kept down the best we could, and the ice-water dressing continued. Adhesive plaster and collodion were used also. Wire sutures were used several times during the following two months as required, and the plaster and collodion had to be applied repeatedly, as the growing of the beard loosened it every few days. Nourishment was given daily, and brandy occasionally. Now and then the bowels had to be moved by enema. The tongue could not be protruded for some time, and he could not swallow until about the middle of December; for, until this, everything would pass from the mouth into the cut and out of the throat; and even after he got so that he could swallow with care, he would at times get a crumb of bread or a drop of water, etc. in the cut, and cough a good deal.

The outer side healed slowly, and about February 15th, 1881, the union was complete, leaving an ugly cicatrix; but in a few weeks it became absorbed, and now it requires rather careful observation to see the cicatrix.

His mind was quite clear for a few days while he was in bed, but his delusions returned, and I suspect that he would commit suicide now, if he had an opportunity.

The main point in this case is the non-use of ligatures. The only unpleasant symptom during the time was a tendency to erysipelatous inflammation on the fourth day, but it soon abated.

At the date of writing, June 20th, 1881, he is up and about as usual, and has no trouble in eating anything.

* Reprinted from the *Transactions of the Medical Association of Georgia, 1881.*

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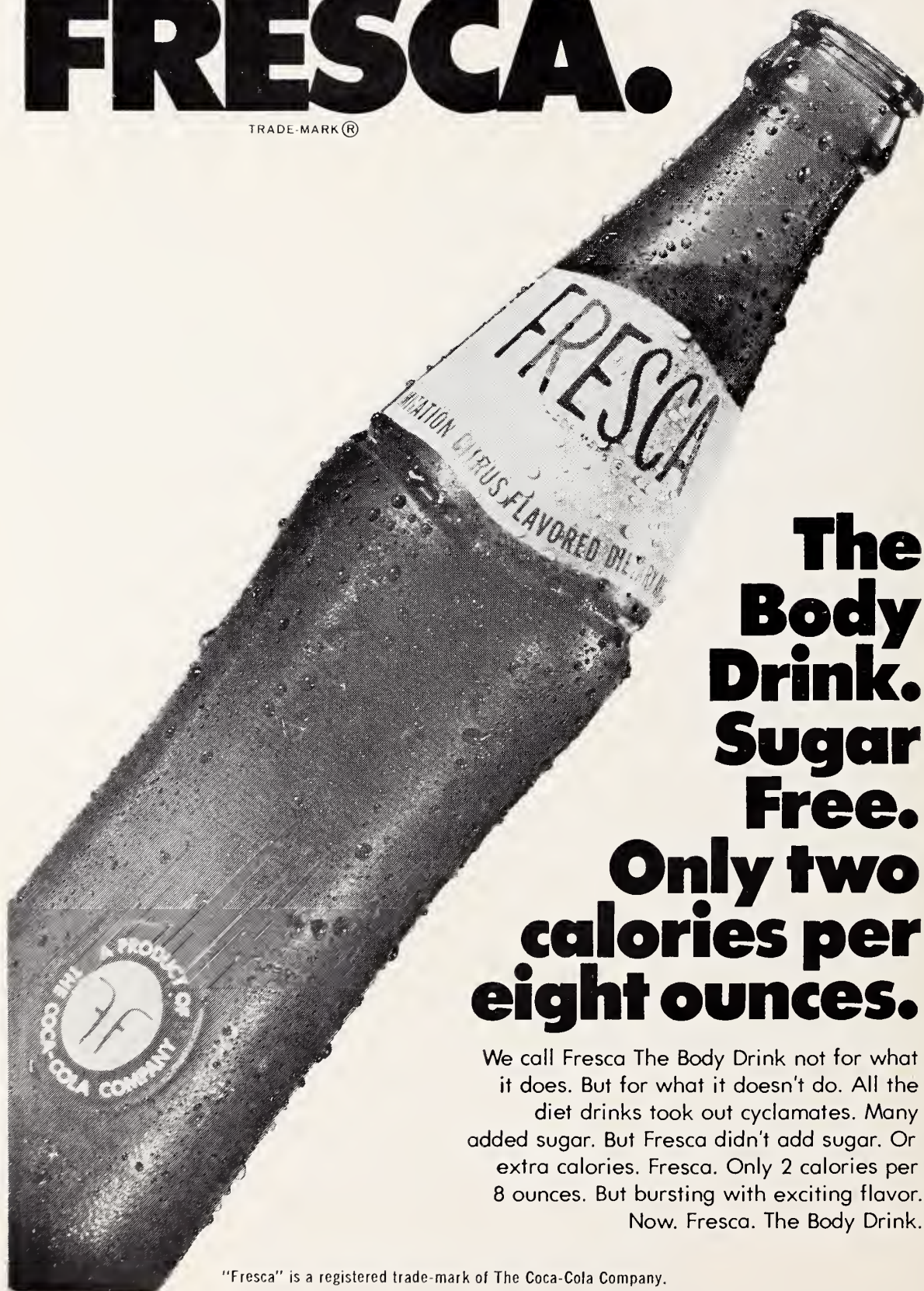
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Contents

Scientific Articles

PHYSICIAN ATTITUDES TOWARD HOSPITAL ABORTION IN GEORGIA—1970	
Malcolm G. Freeman, M.D. and William L. Graves, Ph.D.	437
MALLET FINGER—A REVIEW OF THE LITERATURE	
Stephen N. Barnes, M.D., Joe D. Christian, Jr., M.D. and James L. Becton, M.D.	455

Special Articles

ETHICAL ASPECTS OF "THE FINAL REVOLUTION": MIND MANIPULATION AND JUDAEO-CHRISTIAN ETHICS	
Kenneth Vaux, Th.D.	447
THE INDIVIDUAL MEMBER, THE COUNTY SOCIETY, AND THE MEDICAL ASSOCIATION OF GEORGIA	
Harrison L. Rogers, Jr., M.D.	452

Editorials

THE ABORTION SURVEY	
John L. Moore, Jr.	459
COUNTY SOCIETY OFFICERS' CONFERENCE SCHEDULED	460

Features

President's Letter	461
Cancer Page	463
Heart Page	464
Cumulative Index	16A

The Association

New Members	466
Personals	466
Deaths	466
Month in Washington	468

Cover

The spirit of the Christmas season is aptly illustrated in our cover drawing of the Three Magi, by Marie Seaman.

Physician Attitudes Toward Hospital Abortion in Georgia—1970*

MALCOLM G. FREEMAN, M.D., *and*

WILLIAM L. GRAVES, Ph.D., *Atlanta*

IN THE SPRING OF 1970, the House of Delegates of the Medical Association of Georgia authorized the Association's Maternal and Infant Welfare Committee to conduct a survey among physicians in the state. The survey's purpose was to determine current attitudes toward abortion and to determine what type of abortion law would be supported by the medical profession.

On September 16, 1970, in accordance with this authorization, the Committee sent questionnaires to 3,263 active members of the Medical Association of Georgia and to 445 inactive members. The inactive category includes associate, affiliate, honorary and service members. By October 12, 1970, 1,869 completed questionnaires from active members and 174 completed questionnaires from inactive members had been returned. This is an overall response of 55.1 per cent. The present study, therefore, is a survey of opinions from 2,043 Georgia physicians.

Questions

In addition to identifying data on membership status, age, sex, type of practice, religion, population of residence, and year of graduation from medical school, the following attitudinal questions were asked:

1. Do you approve of abortion if the life of the mother would be endangered by continuation of the pregnancy?

2. Do you approve of abortion if the pregnancy results from rape?

3. Do you approve of abortion if the pregnancy results from incest?

4. Do you approve of abortion if there is a significant risk that the baby would be deformed?

5. Do you approve of abortion if the physical health of the mother would be injured by the pregnancy?

6. Do you approve of abortion if the mental health of the mother would be injured by the pregnancy?

7. Do you approve of abortion for social reasons such as an unwed mother?

8. Do you approve of abortion for social reasons such as multiparity (four or more living children)?

9. Do you approve of abortion for social reasons such as pregnancy in a woman of age 35 or greater?

10. Do you approve of abortion for economic reasons such as parents cannot afford another child?

11. Do you approve of abortion for birth control failure such as a woman pregnant with IUD in place?

12. Should abortion by a competent physician be available upon her own request to any woman capable of giving legal consent?

13. Which of the following would you prefer?

a. No legal abortions available

b. Georgia's present abortion law remain

c. Some further liberalization of Georgia's law to include social reasons for abortion

d. Abortion on request during the first 12 weeks of pregnancy

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† Eugene L. Griffin, M.D., Chairman

- e. Abortion on request during the first 20 weeks of pregnancy
- f. Repeal of all abortion laws with abortion decided by physician and patient alone
- g. Don't know
- 14. Should the husband's consent for an abortion be required if the husband is available?
- 15. Should abortions be required to be performed:
 - a. Only in hospitals accredited by the Joint Commission on Accreditation of Hospitals
 - b. Only in hospitals licensed by the State Department of Health
 - c. In a hospital with no restrictions

General Responses

Responses of the entire group to the survey questions will be considered first, after which specific responses according to the various subcategories of respondents will be considered in detail.

It is apparent from Table I that there is a core group of questions about which almost complete consensus exists. These are essentially the indications set forth in Georgia's 1968 law and include abortion for risk of mother's life, rape, incest, fetal deformity, physical health, and mental health. Responses to all but one of these were greater than 90 per cent favorable. Slightly more than 82 per cent of respondents favor abortion when there is risk of damage to mental health.

TABLE I GENERAL RESPONSES TO SURVEY QUESTIONS IN PERCENTAGES					
	Yes	No	No Opinion	Other	No Answer
Mother's life ...	97.5	1.8	0.3	0.4	
Rape	95.1	3.0	0.6	1.3	
Incest	91.9	4.5	2.6	1.0	
Fetal deformity .	92.5	4.8	1.2	1.6	
Physical health .	90.4	4.9	1.4	3.3	
Mental health ..	82.8	8.7	3.3	5.2	
Unmarried	61.3	28.5	3.5	6.7	
Multiparity 4+ .	54.2	38.7	2.9	4.2	
Over age 35	44.1	46.5	4.9	4.6	
Economic	53.8	39.0	3.4	3.8	
Contraceptive failure	53.4	36.3	6.2	4.1	
On request	48.9	35.3	—	—	15.8
Consent of hus- band required	81.7	17.0	—	—	1.3

When additional considerations for legal abortion are examined, however, unqualified approval by the respondents is less complete. Abortion for unmarried pregnant women is approved by 61 per cent of the respondents and abortion for multiparity, eco-

nomie reasons, and contraceptive failure by more than 53 per cent.

Abortion at the request of the patient without other qualifications was approved by 48.9 per cent and rejected by 35.3 per cent. Abortion for maternal age over 35 was approved by only 44.1 per cent and rejected by 46.5 per cent.

There is general agreement that the consent of the husband should be obtained—more than 80 per cent of respondents so indicated.

TABLE II ABORTION LAW PREFERRED		
	Per Cent	Number
Abortion illegal	1.1	23
Continue present law	16.3	332
Add social considerations	25.9	530
On request first 12 weeks	11.4	232
On request first 20 weeks	4.7	96
Repeal all laws	33.4	683
Don't know	7.2	147
Total	100.0	2043

Indicated Preferences

Preference for future abortion law is considered in Table II. Only 1.1 per cent of respondents believe abortion should be made illegal. Slightly more than 16 per cent would prefer to see a continuation of the present law rather than any significant revision. (It is uncertain which version of the "present law" they support. The law as passed by the General Assembly in 1968 was significantly modified by a three judge Federal panel in July, 1970. The three judge Federal panel declared the indications for abortion as specified in the law to be unconstitutional while retaining the system of proposing physician, consultants, and the therapeutic abortion committee. These changes occurred in advance of the survey, and an attempt was made to publicize them through county medical societies. It is uncertain how familiar the respondents were with these recent events.)

Seventy-five per cent of respondents felt that significant additional liberalization of Georgia's abortion law should occur. One-third of all respondents felt that all abortion laws should be repealed and that abortion should become a purely medical decision between patient and physician. This would remove abortion by a licensed physician from the realm of law and allow the individual physician or the medical community to determine policy under which abortions might be done. Abortion on request during the first 12 weeks of pregnancy was the preference of 11.4 per cent and abortion on request during the first 20 weeks of pregnancy was the choice of only

4.7 per cent. The second most frequent choice was the addition of social considerations to legal abortion. Slightly more than 25 per cent of respondents selected this alternative.

Membership Status

Forty per cent of the inactive respondents are 70 years of age or older and 23.6 per cent of this group graduated from medical school before 1920. Only 0.2 per cent of the active respondents graduated before 1920. In general, the data from inactive respondents show remarkably close agreement with those of active respondents. Exceptions include an increased percentage of "no opinion" answers to questions about abortion for incest and for possible fetal deformity. When asked what kind of abortion law they preferred (Question 13), 11.5 per cent of the inactive respondents answered "don't know," while only 6.8 per cent of active respondents made this choice. Because these differences are relatively minor and will be adequately considered under "age," no further breakdown by membership status will be presented.

Sex

Seventy-eight (3.8 per cent) of the 2,043 respondents were female. A comparison of responses by sex is given in Tables III and IV.

TABLE III
PER CENT OF YES RESPONSES BY SEX

	Male	Female
Mother's life	97.6	94.9
Rape	95.1	94.9
Incest	91.8	94.9
Fetal deformity	92.5	92.3
Physical health	90.5	87.2
Mental health	82.9	80.8
Unmarried	61.3	60.3
Multiparity 4+	54.5	48.7
Age over 35	44.2	39.7
Economic	53.9	51.3
Contraceptive failure	53.5	51.3
On request	48.8	51.3
Consent of husband required	82.4	64.1
No. of respondents	1965	78

The frequently expressed opinion that abortion would be much more readily available if it were controlled by women is apparently not true for women physicians. In this small sample, at least, women were slightly more likely to give restrictive responses than men in all categories except three. More women favored abortion for incest (94.9 per cent to 91.8 per cent) and on request (51.3 per cent to 48.8 per cent). Equal percentages favored abortion for risk of fetal deformity. Female respondents differed most strongly from males on the necessity of securing the

TABLE IV
ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY SEX

	Male	Female
Abortion illegal	1.2	0.0
Continue present law	16.4	12.8
Add social considerations	26.2	19.2
On request first 12 weeks	11.2	16.7
On request first 20 weeks	4.6	6.4
Repeal all laws	33.4	33.3
Don't know	7.0	11.5

husband's consent. Approximately 82 per cent of males felt such consent necessary, while only 64 per cent of females agreed.

On considering future legislation, fewer women than men would choose to continue the present law unchanged or modify it by adding only social indications. A greater percentage of women than men would allow abortion on request during the first 12 or 20 weeks of pregnancy. In spite of these differences, the most frequent response given by both women and men was repeal of all laws and the second most frequent response was the addition of social considerations.

Age

As expected, there is a relationship between the age of the respondent and the year of his graduation from medical school. However, these will be analyzed separately in Tables V-VI and VII-VIII.

There were essentially no differences by age in the tendency to approve abortion for core reasons. Physicians 65 years of age and over were slightly less likely to approve abortion for incest, but otherwise the consensus noted with respect to these indications held up irrespective of age. Also, there were no age differences in responses to the question concerning husband's consent for abortion.

On all other questions, however, increasing age was generally associated with a decreasing tendency to approve abortion. Differences between adjacent age groups tended to be slight with occasional reverses of the general trend, but differences at the extremes of age varied from 15 per cent to 20 per cent in most instances. Abortion for women over 35 years of age was approved by 56.7 per cent of physicians 30-34 but only 25.6 per cent of physicians 70 and over, a difference of more than 30 per cent.

There were only five respondents in the category age 25-29. These five were unanimous in approving abortion in all instances except for one who defected on the issue of fetal deformity. While the number of respondents in this age group is too small for statistical reliability, it suggests that a survey

of medical students and house officers might yield significantly different opinions from those expressed by the majority of older physicians.

When preferences for future laws are examined, several clear trends according to age are apparent (Table VI). Older respondents are more likely to favor making abortion illegal or retaining the pres-

ent law than are their younger colleagues. Younger respondents are more likely to advocate repeal of all abortion laws or allow abortion on request during the first 20 weeks of pregnancy.

In each age group except 55-59 and 70 plus, the most popular choice was repeal of all abortion laws. The most frequent choice in those two groups, the addition of social considerations, was the second most frequent choice of all other groups.

TABLE V
PER CENT OF YES RESPONSES BY AGE

	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Mother's life	100.0	97.9	96.6	98.9	96.2	98.3	100.0	97.6	97.3	91.5
Rape	100.0	95.2	94.7	96.0	94.0	94.7	96.4	95.9	93.2	96.3
Incest	100.0	93.6	92.9	93.4	91.0	91.9	95.8	91.9	85.1	78.1
Fetal deformity	80.0	94.7	91.3	94.4	92.9	93.7	93.4	90.2	91.9	80.5
Physical health	100.0	92.5	90.2	91.0	88.8	91.9	93.4	88.6	87.8	84.2
Mental health	100.0	84.5	84.1	83.8	79.2	86.0	85.0	80.5	71.6	81.7
Unmarried	100.0	70.1	66.7	63.3	57.1	61.8	58.7	57.7	48.7	43.9
Multiparity 4+	100.0	61.0	59.0	55.1	53.3	52.3	50.9	52.0	41.9	42.7
Age over 35	100.0	56.7	50.5	45.5	45.6	41.4	34.1	35.0	28.4	25.6
Economic	100.0	62.0	60.6	54.0	52.5	50.9	49.1	51.2	39.2	42.7
Contraceptive failure	100.0	63.1	56.4	55.1	53.6	51.2	46.1	51.2	40.5	43.9
On request	100.0	59.4	55.8	49.5	44.8	41.8	45.5	48.0	39.2	46.3
Consent of husband required	100.0	78.6	81.2	84.8	83.6	79.3	80.2	79.7	82.4	80.5
No. of respondents	5	187	378	376	366	285	167	123	74	82

TABLE VI
ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY AGE

	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Abortion illegal	0.0	0.0	1.9	0.8	1.1	0.7	0.0	1.6	2.7	3.7
Continue present law	0.0	10.7	12.7	17.6	18.3	16.8	13.2	19.5	21.6	25.6
Add social considerations	20.0	22.5	24.6	27.9	25.1	26.0	34.1	21.1	28.4	23.2
On request first 12 weeks	20.0	9.6	10.6	10.9	12.3	10.9	12.6	14.6	8.1	13.4
On request first 20 weeks	0.0	10.7	6.1	4.3	3.6	3.9	3.0	2.4	2.7	3.7
Repeal all laws	60.0	40.6	38.4	31.7	33.3	33.3	28.7	31.7	29.7	17.1
Don't know	0.0	5.9	5.8	6.9	6.3	8.4	8.4	8.9	6.8	13.4

Year of Graduation From Medical School

Designation of respondents by the year of graduation from medical school establishes cohorts which are, in general, age related. However, some wide age variations occur, particularly in the years following World War II. Graduates between the years of 1946 and 1950, for example, include respondents in all age groups between 35 and 69. Independent of age, the year of graduation from medical school identifies a group of people who were exposed to professional education and developed professional ethics in the same era, took graduate training together, and faced similar economic and social problems and pressures in the establishment of their

medical practices (Tables VII and VIII).

The 44 respondents who graduated before 1920 are clearly more conservative in their attitudes toward abortion than the remainder. Only on issues of rape and mental health are these individuals indistinguishable from their colleagues. On the issues of incest, multiparity, economic considerations and contraceptive failure they are joined by the cohort graduating between 1921 and 1930. The cohorts from 1931 through 1960 are relatively consistent in attitude. The two cohorts who graduated between 1961 and 1970 report the most liberal attitudes of any group but even these are modest increases in "yes" responses over the other cohorts.

TABLE VII
PER CENT OF YES RESPONSES BY YEAR OF GRADUATION FROM MEDICAL SCHOOL

	Before 1920	'21-'30	'31-'35	'36-'40	'41-'45	'46-'50	'51-'55	'56-'60	'61-'65	'66-'70
Mother's life	86.4	97.1	97.4	100.0	97.7	95.4	98.5	97.5	98.2	100.0
Rape	95.5	95.2	96.6	94.2	96.0	92.5	95.1	96.1	94.9	100.0
Incest	75.0	86.5	91.4	92.3	92.6	88.9	93.1	93.4	94.5	100.0
Fetal deformity	77.3	90.4	90.5	89.7	94.0	92.5	93.9	92.0	94.5	100.0
Physical health	79.6	87.5	92.2	91.7	92.0	87.9	90.0	90.9	92.0	100.0
Mental health	79.6	77.9	81.0	84.0	84.6	80.7	81.6	83.7	85.4	94.1
Unmarried	38.6	51.9	58.6	57.1	60.2	59.3	59.9	65.5	70.8	76.5
Multiparity 4+	38.6	43.3	54.3	51.3	54.5	51.8	52.7	57.2	62.8	58.8
Age over 35	20.5	30.8	37.9	33.3	43.5	41.8	45.5	46.7	58.4	52.9
Economic	36.4	44.2	50.9	50.0	51.2	51.8	53.5	57.7	63.9	52.9
Contraceptive failure	40.9	45.2	48.3	50.0	52.2	51.4	52.9	56.1	63.1	52.9
On request	43.2	40.4	50.0	44.9	43.8	45.7	47.1	55.0	57.7	52.9
Consent of husband required	84.1	78.9	79.3	78.9	80.9	85.7	83.4	81.2	79.9	82.4
No. of respondents	44	104	116	156	299	280	391	362	274	17

TABLE VIII
**ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY
YEAR OF GRADUATION FROM MEDICAL SCHOOL**

	Before 1920	'21-'30	'31-'35	'36-'40	'41-'45	'46-'50	'51-'55	'56-'60	'61-'65	'66-'70
Abortion illegal	6.8	1.9	1.7	0.0	1.0	1.4	0.5	1.7	0.4	0.0
Continue present law	25.0	23.1	19.0	15.4	16.1	18.6	18.2	13.0	11.3	11.8
Add social considerations	27.3	23.1	24.1	31.4	29.1	20.7	28.9	24.9	24.1	17.7
On request first 12 weeks	9.1	9.6	15.5	10.3	11.0	13.6	11.8	11.1	8.8	17.7
On request first 20 weeks	2.3	3.9	0.9	4.5	5.0	1.4	4.4	5.5	8.8	17.7
Repeal all laws	11.4	31.7	27.6	32.1	31.1	36.4	30.7	35.1	42.3	29.4
Don't know	18.2	6.7	11.2	6.4	6.7	7.9	5.6	8.8	4.4	5.9

Abortion on request receives a majority approval (over 50 per cent yes) from only three groups, but significantly it is the medical school graduates between 1956 and 1970—the most recent 15 years—who approve.

When future abortion legislation is considered, the same general trends are seen. Only 11.4 per cent of graduates before 1920 chose abortion law repeal, while 18.2 per cent did not state a preference (i.e., answered "don't know" to this question). More than half of this cohort would prefer to continue under the present law or simply add social considerations.

In contrast, 42.3 per cent of the 1961-65 graduates favor repeal of the law. The strongest support for abortion on request during the first 12 or 20 weeks of pregnancy comes from the 1966-70 cohort where 35.3 per cent would favor one or the other law. In general, most cohorts chose repeal most frequently, while only a slightly smaller percentage chose addition of social considerations.

Religion

Abortion is an issue with profound moral and religious overtones. The religious convictions of an individual physician are likely to exert a strong influence over the medical/ethical decision for or against abortion (Tables IX and X).

The general assumption that Catholic physicians are opposed to abortion must be heavily qualified. More than 75 per cent of Catholic respondents were in favor of abortion when the mother's life is at risk. More than 60 per cent favored abortion under conditions of rape, incest or fetal deformity. A clear majority approve abortion when circumstances threaten the physical or mental health of the mother. More than a third of all Catholic respondents favor abortion on request. Approximately 30 per cent approve abortion for contraceptive failure and for unmarried women.

Among Jewish and Protestant respondents the core

TABLE IX
PER CENT OF YES RESPONSES BY RELIGIOUS PREFERENCE

	Catholic	Jewish	Protestant	Other	None
Mother's life	75.4	100.0	98.8	96.4	100.0
Rape	67.2	100.0	96.6	92.7	98.6
Incest	63.9	98.2	93.6	85.5	91.4
Fetal deformity	62.3	98.2	94.2	90.9	92.9
Physical health	54.9	98.8	92.0	87.3	97.1
Mental health	51.6	95.2	83.5	81.8	92.9
Unmarried	32.0	88.6	60.2	60.0	74.3
Multiparity 4+	23.8	75.3	53.6	60.0	67.1
Age over 35	15.6	66.9	43.3	49.1	54.3
Economic	24.6	77.1	53.3	52.7	62.9
Contraceptive failure	28.7	73.5	52.5	58.2	65.7
On request	35.3	72.9	46.2	63.6	65.7
Consent of husband required	80.3	77.1	82.9	76.4	71.4
No. of respondents	122	166	1630	55	70

TABLE X
ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY RELIGIOUS PREFERENCE

	Catholic	Jewish	Protestant	Other	None
Abortion illegal	11.5	0.0	0.4	1.8	1.4
Continue present law	28.7	3.6	16.9	12.7	12.9
Add social considerations	19.7	19.9	27.8	23.6	10.0
On request first 12 weeks	6.6	13.9	11.2	14.6	14.3
On request first 20 weeks	2.5	4.8	4.7	1.8	10.0
Repeal all laws	22.1	53.0	31.5	41.8	45.7
Don't know	9.0	4.8	7.5	3.6	5.7

considerations call forth consistent approval while other considerations invoke variable responses. Abortion when the mother is over 35 and abortion on request earn the weakest affirmative response in both these groups.

Jewish respondents consistently report the most tolerant attitude toward abortion. This may be due to place of residence as well as to religion. More than 68 per cent of Jewish respondents live in a metropolitan area of over 250,000 and more than 88 per cent in an area over 100,000. Attitudes toward abortion are significantly more liberal in large metropolitan areas (see area population).

Opinions are similarly sharply divided on preferences for future abortion legislation. Among Catholic respondents 28.7 per cent prefer a continuation of the present law, whereas only 3.6 per cent of Jewish respondents make that choice. More than 50 per cent of Jewish respondents favor repeal of all abortion laws. Protestant, "other" and "none" respondents favored repeal most frequently and addition of social considerations next most frequently.

Population of the Metropolitan Area in which the Respondent Resides

The attitudes of physicians, no less than other people, are strongly affected by the political and cultural atmosphere which they choose and with which they are surrounded. Also, a physician's attitudes and opinions affect his choice of where he will practice. This environmental factor is at least partially measurable by determining the population of the respondents' residence (Tables XI and XII).

On the core questions there is no substantial disagreement based on population. Each of these questions is supported in approximately the same magnitude by all population groups. The effect of population size is clearly seen, however, on the questions of abortion for unmarried women, multiparity, age over 35, and economic considerations. In each of these four instances progressively increasing approval is found as population size increases. Even abortion for age over 35, which fares the poorest in all categories, earns a scant majority (50.5 per cent yes) in the "over 250,000" group.

TABLE XI
PER CENT OF YES RESPONSES BY POPULATION OF RESIDENCE

	<10,000	10-50,000	50-100,000	100-250,000	>250,000
Mother's life	98.1	99.2	97.7	96.3	97.1
Rape	95.8	95.4	96.0	94.5	94.8
Incest	91.5	92.7	90.8	90.6	92.5
Fetal deformity	91.0	93.8	94.3	91.1	92.6
Physical health	90.1	91.3	86.8	89.6	91.3
Mental health	82.1	82.3	81.0	82.0	84.1
Unmarried	51.9	54.9	54.6	60.8	68.0
Multiparity 4+	42.9	47.8	49.4	51.2	62.0
Over age 35	31.1	38.9	42.0	42.8	50.5
Economic	44.8	46.2	52.3	50.9	60.8
Contraceptive failure	50.0	49.2	46.6	51.4	58.3
On request	41.0	42.9	42.0	46.5	54.9
Consent of husband required	86.8	84.8	81.0	82.3	79.1
No. of respondents	212	368	174	383	881

TABLE XII
ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY POPULATION OF RESIDENCE

	<10,000	10-50,000	50-100,000	100-250,000	>250,000
Abortion illegal	0.5	0.8	0.6	1.8	1.1
Continue present law	24.1	17.9	19.5	18.3	12.4
Add social considerations	29.3	28.8	30.5	26.4	22.9
On request first 12 weeks	12.7	9.5	9.8	11.0	11.8
On request first 20 weeks	5.2	3.8	1.7	4.7	5.6
Repeal all laws	22.6	31.5	28.7	30.0	39.5
Don't know	5.7	7.6	9.2	7.8	6.7

Abortion following contraceptive failure was rejected (46.6 per cent yes) by the "50,000-100,000" group and borderline in three other groups. It was strongly accepted (58.3 per cent yes) by the "over 250,000" group. Similarly, abortion on request, which failed to gain a majority in all other population groups, was supported by 54.9 per cent of those "over 250,000."

Responses to the question of requiring husband's consent are population related. A high of 86.8 per cent of respondents from the smallest communities favored this requirement. The percentage progressively falls as population size increases.

Population size is clearly associated with preferences for future legislation. Continuation of the present law is most strongly supported in the smallest communities and most weakly supported in the largest. The addition of social considerations alone has strongest support in communities less than 100,000 but is supported less often in larger communities. Repeal of all abortion laws is supported by only 22.6 per cent of respondents from the smallest communities but was chosen by 39.5 per cent of respondents from the largest community.

Type of Practice

In the questionnaire, type of practice was subdivided into 20 different categories. To facilitate analysis, respondents who checked allergy, cardiology and neurology were included with internal medicine, and respondents who checked EENT, orthopedics, plastic surgery, thoracic surgery, and urology were included with surgery. Respondents who checked general practice and any other specialization were included under general practice.

In considering the relationship between type of practice and abortion attitudes certain factors relating to population and religion must be considered. For example, in cities under 10,000 population there are no respondents in pediatrics, psychiatry, or dermatology, only one each in ob gyn and pathology, and two in internal medicine. The overall percentages of Catholic and Jewish respondents are 6.0 per cent and 8.1 per cent, respectively. Dermatologists report only 2.9 per cent Catholic and 20.0 per cent Jewish physicians. Catholic physicians make up 11.5 per cent of psychiatrists and 11.7 per cent of anesthesiologists. To some degree these circumstances are related to reported attitudes.

In all types of practice there is general strong support for the core questions of abortion (Table XIII). Wide variations in response to the other questions are apparent. Dermatologists consistently rank as the most liberal group with affirmative votes ranging from 82.8 per cent (unmarried mothers and multiparity) to 65.7 per cent (age over 35). Obstetrician/gynecologists consistently rank as the most conservative. They failed to give majority approval to any of the other six situations with affirmative votes ranging from 42.2 per cent (unmarried mothers) down to only 25.2 per cent (abortion on request). Respondents in all other types of practice gave their lowest affirmative vote to "age over 35," but obstetrician/gynecologists reserved that distinction for abortion on request.

TABLE XIII
PER CENT OF YES RESPONSES BY TYPE OF PRACTICE

	Gen. Prac.	Int. Med.	Surg.	Ob/Gyn	Ped.	Psych.	Derm.	Anes.	Radio.	Pub. Health	Path.	Other	Atlanta Ob/Gyn
Mother's life	98.0	97.2	98.0	97.3	97.3	96.7	97.1	91.7	98.0	91.4	100.0	100.0	97.1
Rape	95.4	94.7	97.1	93.1	91.9	92.6	100.0	91.7	97.0	88.6	98.1	100.0	93.3
Incest	90.3	90.7	94.2	89.9	91.2	91.0	97.1	88.3	96.0	88.6	96.2	95.6	89.4
Fetal deformity	90.0	91.6	94.2	93.6	91.9	92.6	100.0	90.0	93.9	91.4	98.1	91.1	96.2
Physical health	88.3	91.9	94.0	84.9	91.9	88.5	100.0	81.7	92.9	88.6	92.5	88.9	87.5
Mental health	80.1	84.5	85.3	73.9	84.5	87.7	91.4	80.0	88.9	74.3	84.9	84.4	76.9
Unmarried	52.7	65.2	68.0	42.2	57.4	70.5	82.9	66.7	70.7	60.0	77.4	68.9	42.3
Multiparity 4+	43.6	59.6	59.8	31.7	50.0	71.3	82.9	60.0	72.7	54.3	71.7	51.1	35.6
Age over 35	33.2	48.1	48.2	27.1	41.2	59.8	65.7	48.3	59.6	40.0	64.2	51.1	29.8
Economic	43.8	58.1	59.1	33.0	51.4	69.7	77.1	50.0	71.7	60.0	71.7	53.3	39.4
Contraceptive failure	47.6	55.9	56.2	33.5	52.7	66.4	82.9	50.0	63.6	62.9	73.6	55.6	38.5
On request	40.7	51.9	54.4	25.2	45.3	66.4	77.1	51.7	57.6	60.0	56.6	66.7	29.8
Consent of husband required	85.8	79.8	82.2	89.9	79.7	67.2	71.4	83.3	75.8	65.7	86.8	77.8	89.4
No. of respondents	452	322	450	218	148	122	35	60	99	35	53	45	104

Psychiatrists are often thought to hold quite liberal attitudes toward abortion. On the basis of these questions both dermatologists and pathologists seem more liberal and radiologists at least equally as liberal.

The following general statements can be made:

—A majority of all practice groups except obstetrician/gynecologists approved abortion for unmarried women.

—A majority of all practice groups except obstetrician/gynecologists and general practitioners approved abortion for multiparity and economic considerations.

—A majority of all practice groups except obstetrician/gynecologists, general practitioners, and pediatricians approve abortion on request.

—Only in psychiatry, dermatology, radiology, and pathology did a majority approve abortion for women over the age of 35.

A comparison of obstetrician/gynecologists throughout the state and those who reside in the largest metropolitan area (over 250,000) shows slightly more liberal attitudes in the latter group. There is still a consistent failure to approve abortion for any but the core considerations.

When the question of future legislation is examined (Table XIV) sharp divergence in attitude is once again found. Repeal of all abortion laws is the choice of 54 per cent of both psychiatrists and dermatologists. Only 24.3 per cent of obstetrician/gynecologists and 26.8 per cent of general practitioners agree. Other categories give this preference 30-47 per cent endorsement. Only 2.9 per cent of dermatologists would prefer to continue the present law as opposed to 9-17 per cent in most other categories. More than one-third (34.4 per cent) of the obstetrician/gynecologists would prefer continuation of the present law. Abortion on request during the first 20 weeks of pregnancy remains a less common choice (under 7.5 per cent for all categories). Twenty per cent of dermatologists would choose abortion on request during the first 12 weeks as first choice, but only 6.4 per cent of obstetrician/gynecologists would make the same choice.

Again, the obstetrician/gynecologists from the largest metropolitan area (over 250,000) show a somewhat more liberal but similar pattern of choice.

Where to Perform Abortions

Question 15 deals with what manner of health

TABLE XIV
ABORTION LAW PREFERRED—PER CENT OF RESPONSES BY TYPE OF PRACTICE

	Gen. Prac.	Int. Med.	Surg.	Ob/Gyn	Ped.	Psych.	Derm.	Anes.	Radio.	Pub. Health	Path.	Other	Atlanta Ob/Gyn
Abortion illegal	1.8	1.2	0.9	1.8	0.0	0.0	0.0	3.3	1.0	0.0	0.0	0.0	1.9
Continue present law	21.2	12.1	12.0	34.4	13.5	10.7	2.9	13.3	7.1	17.1	9.4	17.8	26.9
Add social considerations	28.3	30.1	26.9	24.3	29.7	12.3	17.1	20.0	25.3	20.0	26.4	13.3	21.2
On request first 12 weeks	11.1	10.3	12.2	6.4	7.4	13.1	20.0	13.3	18.2	8.6	11.3	24.4	7.7
On request first 20 weeks	4.0	5.3	5.1	3.2	7.4	4.1	2.9	3.3	7.1	2.9	3.8	2.2	4.8
Repeal all laws	26.8	34.2	34.0	24.3	31.8	54.9	54.3	35.0	37.4	40.0	47.2	33.3	30.8
Don't know	6.9	6.8	8.9	5.5	10.1	4.9	2.9	11.7	4.0	11.4	1.9	8.9	6.7

facility should be used for abortion. On the questionnaire it was intended that only one of three choices be indicated. The questionnaire's phrasing was meant to determine whether abortion should be restricted to the 83 Georgia hospitals which are accredited by the Joint Commission on Hospital Accreditation or whether abortion should be permitted in any of the 212 hospitals which are licensed by the State Board of Health. No provision was made to allow for office or hospital outpatient abortions.

Many of the respondents chose to indicate both accredited and licensed hospitals. It was arbitrarily decided to classify such responses as signifying accredited hospitals only. Thus, only those respondents who indicated licensed hospitals alone were so designated (Table XV).

Responses to this question can only be interpreted to a limited extent. Clearly, respondents from communities under 10,000 see a definite need to perform abortions in licensed but non-accredited hospitals. Presumably this is the sort of facility most likely to be readily available to their patients.

Discussion

In May of 1969, *Modern Medicine* conducted a poll of physicians throughout the United States asking, "Should abortion be available to any woman

capable of giving legal consent upon her own request to a competent physician?" In Georgia, this question was answered with an unqualified "yes" by 41.6 per cent of 361 respondents. A similar question (Question 12) on the present survey was answered with an unqualified "yes" by 48.9 per cent of 2,043 respondents. This difference is statistically significant at the .025 level.

This difference suggests that medical opinion regarding abortion has become significantly more liberal in Georgia over the past year and a half. This conclusion must be made with reservations, however, since sampling and polling methods were quite different in the two studies. On the other hand, the present survey found that young physicians tend to express more liberal attitudes toward abortion than do their older colleagues, which suggests that medical opinion can be expected to become more liberal in the future.

No objective data exist to show what attitudes the citizens of Georgia as a whole have toward legal abortion or what kind of abortion legislation would be accepted by them. The opinions and statements of various pressure groups do not shed much light on this important issue. It is clear from this study that the physicians who are members of the Medical Association of Georgia feel some further liberalization of legal abortion is necessary. As a group they are nearly unanimous in approving those core considerations set forth in the 1968 law (risk of maternal life, rape, risk of fetal deformity, physical health and mental health). Incest, though not named in the 1968 law, received equal acceptance. There would seem to be no controversy over these issues. Further, a majority of Medical Association of Georgia members approve abortion for unmarried women, multiparity (over four children), economic reasons, and contraceptive failure. Abortion at the request of the mother alone and abortion for maternal age over 35 do not receive majority approval, although a greater percentage approve of abortion on request

TABLE XV
PER CENT APPROVAL OF LOCATION FOR ABORTION BY POPULATION OF RESIDENCE

	Accredited Hospital	Licensed Hospital	Any Hospital	No Answer
Under 10,000 .	41.0	46.2	10.9	1.9
10-50,000	63.9	27.2	7.9	1.1
50-100,000	68.4	20.7	8.6	2.3
100-250,000	65.8	23.5	7.3	3.4
Over 250,000 ..	67.7	20.7	8.6	3.1
Total	63.9	25.1	8.5	2.6

(48.9 per cent) than disapprove (35.3 per cent; 15.8 per cent gave “no answer” to this question). Abortion for maternal age over 35 was the only question that received more “no” than “yes” responses (46.5 per cent to 44.1 per cent).

There appears to be strong support among physicians for some further liberalization of Georgia’s abortion law. Only 16.3 per cent of physicians would prefer to see the present law retained and only 1.1 per cent would prefer to see all abortions made illegal. Just over 7 per cent would not indicate a preference for abortion law, but 75.4 per cent in-

dicated that they favored further liberalization of the law: either the repeal of abortion laws altogether (the most frequent response), the addition of social considerations alone, or abortion on request during the first 12 or 20 weeks.

Interestingly, those who prefer that abortion laws be repealed are not necessarily the most liberal in their attitude toward abortion. Compared with physicians who prefer abortion on request during the first 12 or 20 weeks of gestation, physicians who prefer repeal of abortion laws are slightly less likely to approve of abortion for illegitimacy, multiparity, economic reasons and contraceptive failure. They are also less likely to approve of abortion on request (Table XVI).

TABLE XVI
PER CENT WHO APPROVE ABORTION IN SIX SITUATIONS BY ABORTION LAW PREFERENCE

	Unmarried	Multipara 4+	Age 35 +	Economic	Contraceptive Failure	On Request
Abortion illegal	0.0	0.0	0.0	4.4	8.7	0.0
Continue present law	4.5	2.7	0.9	2.4	6.3	3.6
Add social considerations	60.2	47.2	30.2	44.9	41.7	25.7
On request first 12 weeks	85.8	83.6	70.3	82.3	82.3	87.5
On request first 20 weeks	95.8	89.6	80.2	87.5	87.5	93.8
Repeal all laws	84.5	79.5	70.9	80.1	78.2	77.8
Don't know	34.0	17.7	8.8	20.4	25.9	17.7
Total	61.3	54.2	44.1	53.8	53.4	48.9

It is curious that although 75.4 per cent of physicians preferred some further liberalization of abortion laws, only one of the six questions that go beyond the core considerations already covered by Georgia law (excluding incest) received as high as 61 per cent endorsement. Others received between 44 per cent and 54 per cent endorsement. The data were examined to determine how many physicians approve of abortion in *at least one* of the following situations not covered by Georgia law: unmarried mothers, multiparity, age 35 or greater, economic reasons, contraceptive failure, or on request. More than 73 per cent of the respondents did approve abortion in at least one of these instances. This percentage corresponds fairly closely to the percentage who indicated a preference for some liberalization of the law. Table XVII shows the percentage of physicians approving at least one of the six questions by preference for abortion law. Here again, it can be seen that “repeal abortion laws” is not necessarily the most liberal response. Among those who indicated this preference, 92.4 per cent endorsed at least one of the six indications not covered by Georgia’s present law. This falls between 81.1 per cent for those preferring a law that adds social reasons for abortion and 97.4 per cent of those who would

TABLE XVII
PER CENT APPROVING AT LEAST ONE OF SIX INDICATIONS NOT COVERED BY PRESENT GEORGIA LAW

	Per Cent	Number
Abortion illegal	8.7	23
Continue present law	13.9	332
Add social considerations	81.1	530
On request first 12 weeks	97.4	232
On request first 20 weeks.....	100.0	96
Repeal all laws	92.4	683
Don't know	49.7	147
Total	73.6	2,043

like to see abortion available on request during the first 12 weeks of pregnancy. The most liberal respondents appear to be those who would prefer that abortion be available on request during the first 20 weeks of pregnancy. All of these respondents endorsed at least one of the six situations not covered by present Georgia law. It would appear that there is strong support among physicians for further liberalization of Georgia’s abortion law, but opinions differ as to just what form the law should take.

69 Butler St., S.E.

Ethical Aspects of "The Final Revolution": Mind Manipulation and Judaeo-Christian Ethics

KENNETH VAUX, Th.D., *Houston, Tex.*

WE STAND TODAY at the threshold of "the final revolution."¹ Aldous Huxley used this phrase to characterize the day when technology would be applied not only to matter but to man. Today we have begun the process of "technicization" of man and society. A broad research is going on. A wide spectrum of technique is being developed. Psychobiological and pharmacological means of personal manipulation in concert with electronic media and mass communications as tools of social persuasion create an ambiguous future of promise and threat. We see the individualistic aspect largely in its potential. The ideas and techniques of therapeutic mind manipulation are still largely limited to the laboratories, but the whole range of procedure that Albert Rosenfeld, Senior Science and Medicine Editor of *Life* magazine, vividly chronicles as electro-chemical control of the brain and behavior² is now beginning to break in upon us as a powerful issue.

The socio-political organs of coercion as these manipulate thought and behavior are better known and already operative. We could talk of the systems—education, family, and organized religion have a more positive than malignant effect. Then there are ominous examples: the Stalin Era; the Czech experience from 1967-70, the latent though perhaps overstated threat of Mitchell-Agnewism in our own country. These along with the powerful reflective work of Arthur Koestler³ certainly vivify for us that potentiality and actuality of mass mind control.

"Experimental Reach"

To survey our problem responsibly we must note the way in which the human central nervous sys-

tem comes to be enfolded by "the experimental reach." Just as in molecular biology where the vitalism assumption of Pasteur assumed that no vital process could occur outside the sacrosanct of a living cell, so in our cultural history the mind was considered something special, not vulnerable to empirical analysis. The mind was sacrosanct. This conception is shaped by the Greek body/mind dualism that infiltrates our religious history and the mind/matter distinction that controls our philosophic tradition since Descartes.

Then one night in the 18th century this began to change. Mama Galvani was preparing frog legs for her husband Luigi. They noted the way the legs twitched and jumped when hooked on a copper wire. From the time of Galen in second century Greece men believed there was a spirit, an *anima* that activated neurologic impulse. Galvani's frog legs began a long process of discovery in which men came to see nervous system function in terms of electrical and chemical process. It is this history that frames the question which we search out at this Symposium.

Neurophysiology, psychopharmacology and cybernetics are new disciplines that give attention to the dynamics of mentation. The attendant ethical problems are social and humanistic, thus demanding the interdisciplinary attention this Symposium has convened.

In this essay I will summarize what appear to be the parameters of the problem; suggest the way that the tradition of Judaeo-Christian anthropology considers this development; then finally suggest some ethical guidelines that might propel our wisdom in her urgent efforts to catch up with our knowledge.

Tripartite Problem

The problem is at least tripartite. We must con-

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sider electronic manipulation of the brain, chemical control of behavior and manipulation of the corporate mind through mass media.

In brief summary, electrical manipulation of the brain involves two kinds of activities. First, there is the direct intervention into an individual's central nervous system. This can occur through implanting electrodes or otherwise initiating or stimulating the electrical activities of the brain. Secondly, there is the activity of reduplicating or extending central nervous system activity with the machine, principally the computer. The initial capacity enables us to heighten or diminish cerebral activity through introduced electrical stimulus. We are able, or will be able to relieve pain, stimulate pleasure, intensify or eradicate memory, provoke sexual activity, control anger, induce euphoria.

The second capacity, cybernetic activity, enables us to extend the central nervous system into the world. The machine enlarges the power of the human brain, extending its activity through anticipatory planning, decision making and feedback analysis. In this activity man harnesses more of the cosmic energies to the nexus of his brain. He thus transforms reality into what authors have variously called "the global electronic village,"⁵ or "noosphere."⁶

Chemical manipulation of the brain involves drug-induced alteration of behavior; heightened or diminished awareness via the wide range of stimulants, depressants and psychotropic agents. The techniques that concern us here also introduce the tantalizing prospects of chemical transference of knowledge and experience.

The social ramifications of chemical manipulation are perhaps more ominous than electrical means. Chemical warfare and recent threats from militant circles to detonate charges or drop LSD in a city's water supply are illustrations of this ominous prospect. (To effect a change in human functioning by altering the chemistry of what he ingests or breathes or senses is a frightening capacity.)

The social forms of mind manipulation are vivid and need no enumeration. Needs are created according to vested interests. Through advertising, political ideology is introduced and enforced. Patterns of perceiving and thinking are altered in the feedback cycles initiated as human extensions create environments.

Theological Viewpoint

To consider these matters in a theological context it is necessary to look at the Judaeo-Christian anthropology, particularly the facets of that anthropological tradition which bear down on concerns of the mind.

In Hebrew, the profound level of perception which springs from the unified bio-spiritual being is to be found through man's mind. Hebrew man feels, knows and perceives in one unitive act. The Hebrew verb for knowledge is also used for human intercourse. In other words, the essence of the Hebrew understanding of mind is relatedness; relatedness to God, to man, to Torah. The mind, in other words, is the mystical, rational and emotional contact man has with objective reality and the *Thou*.

In the Greek world, notions of reason and mind (Logos) are refined and sharpened. Man's mind can be the instrument of his glory or his hubris expressing his ascent or fall, depending on your answer to the Tertullian question, "What has Athens to do with Jerusalem?"

In Greek wisdom, man's reason is his link with the rational nature of things. It may be a divine spark or spirit as in Stoicism or the structural soul as in Aristotle. Underlying this differentiation^{6a} is the belief that the mind is the capacity guiding man's perception of reality. Mind serves to link man to eternal reality (Plato) or structurally order his being, teleologically drawing personality toward fulfillment and destiny (Aristotle).

Roots of Understanding

From these roots, Jewish and Greek, emerge the Christian understanding of mind, soul and conscience. In Christian tradition the consciousness of man in cognitive, emotive and ethical aspects is only deepened and complicated rather than simplified. Our scientist colleagues may wonder why the theologians have so little to say about mind manipulation. They may hope that at long last we have stopped pontificating on things we know nothing about. Let me assure you that is not the case. Our confusion results from not knowing what on earth the mind is.

Before valuative statements can be made with reference to mind manipulation, we must grapple with this problem. What entity or function called "mind" is, or should be, unmanipulatable and why? The classic philosophic reflection on the mind-body interface seems to have lost its intrigue. We can talk about the mind structurally or functionally. Each perspective affords different ethical directives. If we focus structurally, biological intervention might be most objectionable. If we talk about the mind functionally, either in Freudian personality terms, ego, super-ego, etc.; or philosophically, talking of freedom, responsibility, etc., a different constellation of values would emerge as important.

When the subject of mind is discussed people look at it from at least three perspectives. Neurophysiologists and psychopharmacologists stress the brain as a system activated by electro-chemical and psy-

chic processes. Philosophers stress mental qualities: freedom, choice, responsibility. This latter tradition runs deep in philosophy through Kant's *Reine and Praktische Vernunft* (pure and practical reason) back to Plato and Aristotle. Although each of these emphases, structural and functional, emerge in Christian history, the unique contribution of theological thought is to see the ethical reality of mind.

Christian Anthropology

In Christian anthropology man's uniqueness resides not in his brain, majestic and marvelous as it is, nor does it lie in his reason. Theology finds the grandeur and uniqueness of man's mind—his reason—located in his responsibility. Relatedness, personal responsiveness to another, *verantwortung*, answer-ability, communicativeness between man and God, man and man; this is the mental genius of man. Man is more than an animal, even a rational animal. He is a moral being, a responsive, responsible creature. Emil Brunner, for example, stresses that reason is not an entity but a relation.⁷ Ethically speaking, man is a man only when he can personally relate and decide. Humanity is active in the presence of interpersonal, intra-psychic and transcendent relatedness, and in the exertion of moral discernment.

The components of the Judaeo-Christian tradition highlight different aspects of mind. Roman Catholic thought accents the organic nature of mind. Jewish theology is focused on the rational aspects of mind. In Protestant thought the relational stress is made. The unified stream running through the rich tradition, however, is the view that man is a personal being, unique in his capacity to relate as "thou" rather than "it" and in his moral capacity to understand and stand under the Word of God.⁸

Before passing from this section on Judaeo-Christian anthropology, reference must be made to the Marxist view of man. There are two reasons for this: first, Marxism is the major secular *weltanschauung* and *mensch bild* that Judaeo-Christian tradition has spawned. Secondly, the secular humanism of Marxism may well prove to be an appreciated "soul brother" if the world continues to propel itself toward more nihilistic, anti-human ideologies. Marxism emerges in Western philosophy via Hegel. It combats all forms of alienation of man. In the words of Czech scientist Jan Kamaryt, "it (Marxism) is directed against all attempts of reducing man to a manipulable being. This has led . . . to Marx' concept of the free, total and productive man."⁹

Free and deliberate choice is a fundamental quality of man's inner being, which is open, always in the process of becoming. These elements of free being and overcoming alienation are cardinal Marxist tenets. We know how frequently they are suspended

or abrogated in the socialist state. We can also question whether real mental and soul freedom are possible in a social order which clings to either atheism or anti-theism as "politically enforced values." Despite these objections and the unfortunate vulnerability of Marxist nations to freedom negation through cybernetic control and planning, we would be wise to move from anathema to dialogue.^{9a} We should accept and foster the mind humanism of that tradition as together we face the terror and promise of mind manipulation.

Relate Insights

In conclusion, allow me to attempt to relate these anthropological insights to the present and potential problems of mind manipulation. It seems important initially to set the ethical context. I have argued elsewhere for an ethical decision-making model where the responsible self is sensitive to all the signals that reverberate through the context.¹⁰ This ethic is responsive not only to insights from tradition but also to present networks of relation and mutual effect. It is also responsive to the future.

Let me illustrate this: we are confronted with a decision to require a surgical or electrical intervention into the mind processes of a person carrying the abnormal XYY chromosome. Although genetic manipulation might be a more appropriate procedure, let us assume that mind manipulation can serve the same purpose of stopping violent behavior or even transforming this into sweetness. The ethical context might be bombarded with signals from behind, ahead and the sides. Tradition might remind us of the violent capacity engraved in the being of all men in the mark of Cain. It might remind us that "being my brother's keeper" is a matter of free will. In this case of XYY we might disallow or justify brain manipulation because he is either *free* or *not free* biologically to be his "brother's keeper." Another normative signal from memory might be the classic restraints on human experimentation. Horizontally or laterally the context might receive signals regarding the social desirability of intervention. Family concerns, public safety and the common law insight of right of protection from oneself might find meaning in this case.

The signals from the future might include the genetic load prospect if this deleterious trait is not isolated. It might consider the feedback effect of allowing or disallowing this form of mind alteration to occur. All of these factors—retrospective, prospective and circumspective—seem to impinge upon any given decision, constituting its ethical context.

Ethical Options

Here, I believe, we are approaching what has classically been called the discernment of "the Will of

God." This certainly is the impetus and directive that is ultimate in any ethic. A strong synthesis of traditionalism, situationalism and futurism appears to be the only responsible way to act with reference to these great crisis questions. The alternatives are a collapse into fatalism or legalism, to which men are perennially prone. These are not ethical options open to responsible men today.

H. Richard Niebuhr, on his study of *The Responsible Self*, succinctly summarizes the kind of ethic I'm opting for. He does it by contrasting responsive ethics to the idealist and legalist options. Monotheistic idealism says: "Remember God's plan for your life." Monistic deontology commands: "Obey God's law in all your obediences to finite rules." Responsibility affirms: "God is acting in all actions upon you. So respond to all actions upon you as you respond to his action."¹¹

Accepting this model of a responsiveness ethic in a context open to past, present and future, seems to propose several moral directives on this question of mind manipulation. I mention these in conclusion:

A. The Gerard thesis that "there can be no twisted thought without a twisted molecule"¹² needs to be understood together with a biblical insight. It comes from Jeremiah: "The heart is deceitful about all things, and desperately corrupt; who can understand it? I the Lord search the mind and the heart" (Jeremiah 17:9-10 RSV). Our mind scientists and therapists should be encouraged in their efforts to heal pathologies that are organic in origin, giving rise to violent behavior. We should not allow ourselves the simplistic view of man, however, which reduces all human evil or good to disturbed electrochemical process. This would deny the richness of human freedom and will, miss the power involved in man's "intentionality"¹³ and distort the spectrum of human activity under God that makes him a man: hate, despair, repentance, love, aspiration. To see these activities as molecular not only in action but in origin would lead to a disastrous anthropology and by consequence justify a frightful range of mind manipulation technique. The Gerard statement is fully acceptable, unless we interpret it to mean that the twisted molecule is the sole and sufficient cause of the twisted thought. We must allow the extracerebral elements of mind. Judaeo-Christian ethics would argue that man is a moral being. Although his good and evil intentionality may have organic expression it is rooted in the way that personal being relates to "the ground of being" and fellow humanity.

B. Dr. Delgado's postulate that "we can intelligently manipulate the cerebral determinants of behavior"¹⁴ prompts an observation and suggested guideline. I question the assumed *intelligence* of man. Reinhold Niebuhr commented that sinfulness is the most empirically verifiable human fact. Koestler speaks of the strain of insanity that runs through our species. At recent senate hearings on this subject, Senator Walter Mondale of Minnesota posed the question: "Are we wise enough to be so smart?"¹⁵ With reference to genetic manipulation, Marshall Nirenberg said: "When man becomes capable of instructing his own cells, he must refrain from doing so until he has sufficient wisdom to use this knowledge for the benefit of mankind."¹⁶ I tend to agree with these notions. Dr. Delgado claims that our scientific progress has a momentum that cannot be halted or reversed. He expresses the well-founded fear of Robert Oppenheimer that what is technically sweet becomes irresistible. Delgado phrases his pessimism this way:

"It would be irrelevant to discuss whether physical control of the mind should be accepted or rejected since history proves that when technology has been available, it has been used and developed regardless of possible dangers or moral issues."¹⁷

Although history certainly bears out the argument, we cannot allow ourselves to slip into fatalism. Although this has been true it need not be true for us. We can say "no" to alluring avenues of research. Our universities can refuse government grants. We can exert political influence to prevent destructive use of our technology. With Norbert Wiener we can refuse to give research insight to irresponsible militarists.¹⁸ We can develop scientific conscience in the life sciences as physicists attempt to do in the *Bulletin of atomic scientists*. Fortunately, a profound moral consciousness is emerging in the scientific community. There is evidence of this in the humanistic direction of the distinguished scientists at this meeting. The dynamic understanding of personality, forged in the crucible of Jewish and Greek anthropology, cherished in the Judaeo-Christian ethic, would call us to creative aspiration, not acquiescence. These facets of Judaeo-Christian ethics with historical openness and hope that inform that tradition prompts us to use our science and technology for human fulfillment rather than destruction.

Open Future

Our future is open. It throbs with human responsibility because it is God's future. Karl Rahner states it succinctly: "In the obviously growing open-

ness to the future and its planning—the dialectic of increased planning and unplanned contingency . . . God's absolute future perhaps shows itself in silent presence.”¹⁹

We stand at the threshold of “the final revolution.” Psycho-civilization is beginning to break in upon us. The promise is evident. Pain, suffering, the great environmental problems, hunger, war—all intensify in world civilization as challenges that cannot be answered without “intelligent technology.” Man cannot survive on earth without his science and technology. That is clear. The question is, can he survive with his technology?

*The Institute of Religion,
Texas Medical Center 77025*

FOOTNOTES

- ¹ Aldous Huxley, *Brave New World* (New York: Bantam Books, 1954).
- ² Albert Rosenfeld, *The Second Genesis* (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969).
- ³ Arthur Koestler, study of *The Ghost in the Machine* (New York: Macmillan, 1967), points out the self-destructive tendencies in man which are heightened in technology. *Darkness at Noon* (New York: The Macmillan Company, 1941) was one of the first works to remind the English-speaking world of the psycho-social terror of mind control.
- ⁴ Good introduction to the three aspects of mind manipulation are found in Seymour M. Farber and Robert H. L. Wilson, eds., *Control of the Mind* (New York: McGraw-Hill, 1961), Jose Delgado, *Physical Control of the Mind: Toward a Psychocivilized Society* (New York: Harper and Row, 1970); and Albert Rosenfeld, *The Second Genesis: The Coming Control of Life* (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969).
- ⁵ Marshall McLuhan, *Understanding Media: The Extensions of Man* (New York: McGraw-Hill Company, 1964).
- ⁶ Pierre Teilhard de Chardin, *The Phenomenon of Man* (New York: Harper Torchbooks, 1955).
- ^{7a} The classic formulation of the rational nature of mind and reality and the microcosmic/macrocyclic relation of man's reason and nature is found in *The Republic of Plato*.
- ^{7b} Emil Brunner, *Man in Revolt* (Philadelphia: The Westminster Press, 1939).
- ⁸ Expressions of this point were many and varied in the literature. See for example: Martin Buber, *I and Thou* (New York: Charles Scribners Sons, 1958); Karl Barth, *Church and Dogmatics III*, 2 45 (Edinburgh: TOT Clark, 1956); and Helmut Thielicke, *The Ethics of Sex*, translated by John W. Doberstein (New York: Harper and Row, 1964).
- ⁹ Jan Kamaryt, *Principles of the Marxist Understanding of Man and Humanism*, in Hans Rudi Weber, ed., *Experiments With Man* (Geneva: World Council of Churches, 1969), p. 68-69.
- ^{10a} Roger Garaudy, *From Anathema to Dialogue*.

- ¹⁰ Kenneth Vaux, *A Year of Heart Transplants: An Ethical Valuation*, *Journal of Postgraduate Medicine*, Volume 45, No. 1, January, 1969.
- ¹¹ H. Richard Niebuhr, *The Responsible Self* (New York: Harper and Row, 1964), p. 156.
- ¹² Rosenfeld, *Op. Cit.*, p. 190.
- ¹³ For a discussion of the meaning of intentionality see Rollo May, *Love and Will* (New York: Norton Books, 1969).
- ¹⁴ Jose Delgado, *Brain Technology and Psychocivilization*, in Cameron Hall, ed. *Human Values and Advancing Technology*, privately distributed document. This paper is a slightly modified version of a talk given at the Columbia University Seminars on Technology and Social Change, November 10, 1966.
- ¹⁵ See Kenneth Vaux, *Statement before the Subcommittee on Government Research, Hearings on S. J. Resolution 145, To establish a National Commission on Health Science and Society*, Washington, D.C. 1968, p. 138.
- ¹⁶ *Ibid.*, p. 138.
- ¹⁷ Delgado, *Op. Cit.* p. 81.
- ¹⁸ See Norbert Wiener, *The Human Use of Human Beings* (Boston: Houghton Mifflin Company, 1954).
- ¹⁹ Karl Rahner, *Christianity and the New Earth*, in Walter J. Ong, ed., *Knowledge and the Future of Man* (New York: Holt Rinehart and Winston, 1968), p. 268.

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ORTHO ILLUSTRATES SAFETY CONCERN THROUGH AMA JOURNAL

The Ortho Division of Chevron Chemical Company is advertising in a different kind of medium this Fall because they have an unusual message.

The medium is the *Journal of the American Medical Association* and the product is concern. Through its ad, Ortho is offering free distribution of the U. S. government publication, “Directory, Poison Control Centers.”

The message is headlined “This book won’t cost you a cent. Not having it may cost you a life.” Copy simply says:

“Many chemicals are dangerous. That’s why warnings are printed on labels. But accidents can happen. The fastest way to find the proper antidote or treatment is to call your local Poison Control Center.

Write to us: Chevron Chemical Company, 200 Bush Street, San Francisco, California 94104, and we’ll send you a HEW directory of local phone numbers and addresses. It’ll save you time. And maybe patients.”

Widespread distribution of ad reprints are planned for both the medical and chemical fields.

GASTROENTEROLOGY GROUP FORMING

All of those physicians in Georgia who are interested in Gastroenterology, either as a primary or secondary specialty, and who would like to join a forming group of similarly interested physicians, please contact Dr. James L. Achord, Emory University Clinic, 1365 Clifton Road, Atlanta, Georgia 30322.

The Individual Member, The County Society, and The Medical Association of Georgia

HARRISON L. ROGERS, M.D.,* *Atlanta*

WE HAVE BEEN ASKED to consider the relationship between the County Medical Society and the Medical Association of Georgia. The specific points are to be the programs, policies and House of Delegates' actions of our Association as they are affected by our individual members, as well as the effect these programs, policies and actions have on our individual members.

It seems appropriate to me here to quote from the Constitution of our Association:

1. "It (the MAG) is an Association of its component Medical Societies," and "The purposes of the Association are to promote the science and art of medicine and the betterment of public health."

2. "The House of Delegates is the legislative body of the Association, and it shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws."

3. "It (the Council of MAG) carries out the mandates and policies as determined by the House of Delegates. The Council has full authority and power of the House of Delegates between sessions of that body. The Council has charge of all property and financial affairs of the Association."

Representation

I would like to point out that it is the individual member's vote which sends a man to the legislative body, the House of Delegates. Each delegate there represents 25 of his physician constituents and is obligated to guard their rights as his own. The Council of the MAG, which carries out the directions of the House of Delegates, is composed of Councilors, again elected by the vote of the physician constituents

in his district. Finally, I would remind you that the Speaker and Vice Speaker of your House of Delegates are elected by the individual delegates and bear the responsibility of overseeing the accomplishment of House Directives.

These statements notwithstanding, you and I are both aware that a large number, if not a majority, of the individual members of the Medical Association are totally in the dark as to (1) what the Medical Association of Georgia really is (and I'm sure a large number don't know *where* it is), (2) what the MAG does, (3) who runs the Association, (4) how its programs and policies come into being, (5) how the dues money is spent, and (6) why the Medical Association gets involved in so many different spheres of activity.

Accepting these statements to be true, and I'm sure that if it is for my County Society and its members, then it's probably true for yours, then I agree that a large part of your time and mine must be spent rectifying this situation. I have no doubt but that if everyone read the *Journal of the Medical Association of Georgia* or that of any of those counties publishing journals, he would be well-informed on all these counts. However, it's obvious that our members don't follow this course. So, the responsibility for getting this information to our membership is ours.

Essential Information

To start this task, you and I must be extremely well-informed ourselves, and to this end I plan to go over with you a number of specific points. The first section of our Constitution, which I quoted, gives a concise definition of our organization and points out clearly that it is built from the bottom up—literally, it is an association of its component

* Speaker of the House of Delegates, Medical Association of Georgia. Presented at the MAG County Society Officers' Conference, February 14-15, 1970.

medical societies. For those of us who don't know where the MAG is—as we sit here at the Biltmore we are just two blocks away from the new edifice at 938 Peachtree Street.

To go on to the next section of the Constitution quoted, the House of Delegates is *the* legislative body of the Association. It is to this body that reports, information, resolutions, suggestions for policy statements, or changes in policies previously adopted are brought. It is the responsibility of the House to carefully weigh each item of business brought before it and to render a thoughtful and mature judgment on each.

There are many ways in which a matter may be brought before the House for its consideration:

1. Any delegate to the House may offer a resolution or sponsor a move to effect a change in any part of the Association.
2. Any County Medical Society may instruct its delegate to offer a resolution on any subject.
3. All officers of the Association are required to make a report to the House of Delegates which contains not only a résumé of work accomplished, but also his best advice on the course to be followed in the future.
4. All Councilors and Vice Councilors are required to make a report to the House just as are the Officers, but with special attention to their districts.
5. All committees of the Medical Association are required to submit an annual report to the House including matters considered during the year with suitable background studies, together with the committee's recommendations for action by the House.
6. The AMA Delegation reports each year to the House on its activities, together with any recommendations it may have.

Consideration of Reports

Each of these many reports and resolutions will be considered by the House of Delegates at the Annual Session in May of every year. To reach the best possible decision at that time on every matter, it is an absolute necessity that careful consideration be given to each one *prior* to the Delegates' arrival at the meeting. To this end, each year, well before the annual session, every Delegate, Councilor, Committee Chairman and County Society receive the "Delegates Handbook." This is a compendium of all the reports and resolutions received prior to publication and should be reviewed item by item, either in a general meeting of the society or in a meeting of the Delegates. It is *only by this laborious and time-consuming process* that your Delegates can discuss, amend and finally vote on each item of business with intelligence.

Because some reports and resolutions will not be available when the handbook is published and distributed, they will be reproduced and given to everyone in attendance at the Annual Session on arrival. Furthermore, since resolutions may be introduced "out of the blue" at the first session of the House of Delegates, these will be reproduced and distributed as soon as possible. For this reason, it behooves each delegation to have a caucus at the Annual Session when these late reports are available for your consideration.

This year it will be especially important for you to consider your delegation's role at the House of Delegates meeting, for the election of all Officers, AMA Delegates and Alternate Delegates will occur in the House of Delegates. In the past, nominations for these positions were made at the General Session (first meeting), votes were then cast by the entire MAG membership in attendance and the results announced at the third meeting of the General Session. However, in May, 1969, acting on a 1967 report of the Ad Hoc Committee on Elections, the House of Delegates reversed the election procedure. At this year's Annual Session, nominations for these offices will be made at the first session of the House of Delegates and the election will occur at the last session of the House. The committee recommended this change for three reasons:

1. Election would be by the group most representative and most knowledgeable in the MAG.
2. County Societies' interest in the selection of their Delegates would be enhanced and thereby improved.
3. Interest will be stimulated in the County Societies' meeting to discuss the possible candidates and instructions to their Delegates.

Reference Committees

To return to the operation of the House of Delegates, all business is officially introduced and nominations are made at the First Session of the House. At this time, all matters for consideration by the House will be referred to a Reference Committee. This form of legislative structure, as you know, was developed by the AMA and subsequently adopted by almost all state associations as the most efficient method for evaluation in depth of all aspects of any question. The Reference Committee is usually composed of six delegates from different sections of the State and from varying sized communities. The Committee has instructions from the House of Delegates to consider each item brought before it with the utmost deliberation, to hear from the proponents and opponents of a particular matter, and to in addition seek out their own information. In executive session the committee then makes its formal report.

including its recommendations and reasons for these views.

There are five Reference Committees in all, each with an agenda which seems designed to keep everyone concerned safely away from the temptations of the lighter side of the Annual Session. All Reference Committee Reports and Recommendations are then reproduced for general distribution.

Needless to say, the most effective place to influence the fate of a particular resolution or report is in the Reference Committee's hearings which are open to all members of the MAG. If you as an individual or as the spokesman for a delegation want to support or speak against a particular measure, this is the place to do it. It is your responsibility as an Officer of your County Society to see that you are represented at these hearings. After the Reference Committee Reports are in your hands it is often advantageous to once again caucus with your delegation and decide how you stand on these recommendations.

House Action

The House of Delegates at its Second Session receives these Reports of Committees and will go over them line by line, approving, defeating or amending each proposal. Thus, the programs and policies of the Medical Association of Georgia are formulated. Upon the closing of the House of Delegates it is the responsibility of the Speaker and Vice Speaker to see that all directives of the House are carried out and a report of this activity is given to the Council at each of its meetings. In addition, the complete report of the proceedings of the Annual Session is published in the next issue of the *Journal of the MAG*.

Specific examples of how measures are considered by the House of Delegates and a course of action selected are as follows:

First, an example of a Committee Report with subsequent action:

1. Report of Joint meeting of a) MAG Committee on Finance and b) the Special Finance Committee held in September, 1968.

Recommended dues increase plus a five-year annual assessment for the MAG Foundation.

Sent to the Council.

2. Report of Council May 3, 1969

Recommended a yearly assessment for two years and no dues increase.

Sent to House of Delegates.

3. Report of Reference Committee

Recommended a one year's dues increase and no assessment.

4. House of Delegates Action

Changed the amount of the one year's dues increase recommended by the Reference Committee.

Adopted the change—67 For, 33 Against.

Next, an example of a County Society resolution and action:

1. Resolution on Chiropractic

Approved by local Medical Society, February, 1969.

Sent to the House of Delegates.

2. Report of Reference Committee

Approved.

3. House of Delegates Action

Approved.

Disseminate Information

You have now heard all my specific points concerning the relation between the individual Physician and the MAG. I feel that it is our responsibility, yours and mine, to get this story out to all members of MAG. The only problem is how to accomplish this goal. I'd like to enumerate a few suggestions of mine and others:

1. Indoctrination Meetings—When a new physician joins your Medical Society, some time during his first year he should be told *all* of what you've heard today and will hear in the morning. The new member will hear it all and remember some of it—and this will be a plus.
2. Regular County Society Meetings—The physician who has been in your Society for five, 10 or 15 years, but who has not been active in MAG affairs may be just as poorly informed as the initiate, so plan a meeting occasionally to get this information to him, too. You can get all the outside help you need for these meetings. I haven't checked this with the Vice Speaker, Dr. Ellington, but I'll volunteer our services whenever you call. I am sure that our esteemed Chairman of Council, Dr. Bohler, or President, Dr. Train, or any of the Officers would be flattered by such an invitation.
3. Special Announcements at Regular County Society meetings
 - a. to discuss matters coming up at Council meetings or Annual Session
 - b. to discuss nominations for elected positions
 - c. to discuss MAG activity in general—after all, discussion, whether good or bad, is better than being ignored.

1293 Peachtree St., N.E.

This hand surgery problem may appear quite simple initially, but actually may become considerably complicated.

Mallet Finger

A Review of the Literature

STEPHEN N. BARNES, M.D., JOE D. CHRISTIAN, JR., M.D., and
JAMES L. BECTON, M.D., *Augusta*

MALLET FINGER (Figure 1), caused by rupture of the distal insertion of the extensor mechanism of the finger with or without a bony fragment, is one of the more common tendon injuries. Considerable work has been done regarding the management of avulsion injuries to the extensor mechanism since the first recording of the injury by Segond in 1880. Many techniques have been proposed for adequate treatment of such an injury.

MALLET FINGER

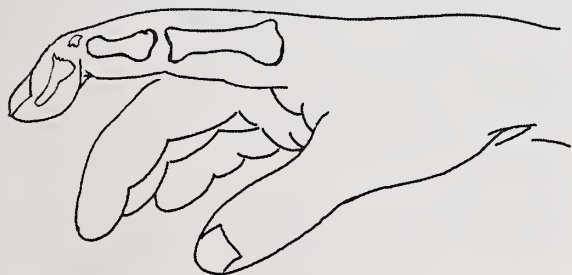


FIGURE 1

The patient is unable to actively extend the distal joint of the finger. There may be an avulsion fracture of the distal phalanx or a rupture of the extensor tendon over the distal joint.

It is the purpose of this paper to review the past and current feelings which concern treatment of mallet finger and to come to conclusions dealing with its proper management.

Anatomy

An understanding of the extensor mechanism of the phalanx is the basis of treatment of this injury.

The extensor aponeurosis (Figure 2) is composed of an intricate system of interdigitating fibrous connective tissue bands and tendinous structures which are assembled in longitudinal, horizontal and ob-

lique axes on the dorsum of the phalanx.¹ In the central portion of the aponeurosis is the long tendon of the extensor digitorum communis which inserts on the proximal dorsal surface of the middle phalanx. The long tendon trifurcates proximal to its insertion over the shaft of the proximal phalanx:² the central tendon slip inserts as above and sends fibers to a fascial sheet continuous with the collateral ligament of the proximal interphalangeal joint; the lateral slips continue to unite with the lateral bands of the extensor aponeurosis. These lateral bands are common tendons formulated of the wing insertions of the dorsal and volar interossei and the lumbrical tendons on the radial sides of the 2nd, 3rd, 4th, and 5th phalanges. The lateral bands are separated by the triangular ligament and are united distally to insert into the distal phalanx. These bands have the capability of shifting toward the volar surface of the phalanx as the proximal interphalangeal joint is flexed.

It is distal insertion of these bands with which we are concerned in this injury, for the disruption of this insertion produces the characteristic mallet finger. Consider the mallet finger presenting anatomically as a result of dynamic motor imbalance. The distal phalanx is usually hyperflexed secondary to loss of distal insertion with normal flexor tone. The middle phalanx may present in some degree of hyperextension due to the pull of the remaining intact extensor mechanism. There is partial to complete loss of voluntary extension at the distal joint with associated pain and swelling. One may observe full passive motion of the distal joint.

Mechanism of Injury

Mallet finger is the result of direct or indirect force to the distal extensor mechanism. Direct trau-

MALLET FINGER / Barnes, et al.

ma could be the result of a laceration or contusion, whereas indirect trauma usually follows sudden excessive flexion at the distal interphalangeal joint while the phalanx is actively extended. This injury occurs in various situations from violence to the simple act of dressing or making a bed. Also referred to as "baseball finger," the mallet finger is often associated with sports activities.

At the time of injury a small fragment of the bony insertion of the lateral bands may be avulsed. The same fragment may be present due to hyperextension with a buttressing effect of the distal phalanx against the head of the middle phalanx.

The incidence of mallet finger varies according to several factors including age, sex and the population studied. Robb³ reports, in his review of 75 patients, a peak incidence of this injury in the 5th and 6th decades with a preponderance to males; fingers most frequently involved were the ring and little in a ratio of 2:1 compared to other digits. Hallberg and Lindholm⁴ report in 126 patients an incidence of approximately 3:1 males to females injured; the greatest number of injuries occurring in the age group 12 to 25 years. The average age injured was 38.8 years. Of all the patients in the latter study, the 4th digit was injured in the greatest frequency. When all females were considered, the 3rd digit was more commonly involved.

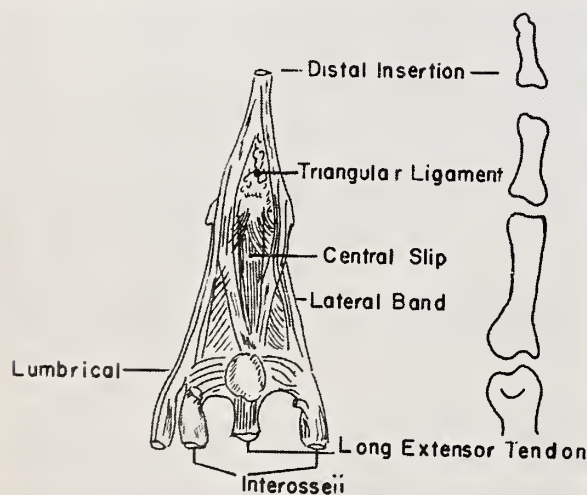


FIGURE 2

The anatomy of the extensor tendon mechanism of the finger.

Treatment

Management of mallet finger is dependent upon both age and the nature of the injury. The main objective is anatomic restoration of the injured part with recovery of function of the extensor mechanism.

Conservative treatment has been widely used. Most methods of immobilization follow the pattern of placing the proximal interphalangeal joint at 60° of flexion and fixing the distal interphalangeal joint in some degree of hyperextension. Recently more attention to the subject of immobilization has suggested that fixation of the distal joint at 0° or at some degree of hyperextension irrespective of the proximal joint is desirable.

The use of external apparatus for splinting has ranged from the use of tongue blades or padded metal splints fixed to the volar aspect of the digit to varying types of casts about the injured digit (Smillie,⁵ Howie, Williams, Bunnell⁶ and Watson-Jones⁷).⁸ Wooden and metal fixation as described do not assure complete immobility, a factor some feel is integral in the repair of mallet finger. Difficulties encountered in using external splints are discomfort to the patient, ease of removal by the patient allowing the possibility of flexion at the distal joint and a greater chance of non-union (Bohler—as per Hallberg) and danger of inadequate circulation of the digit with resultant necrosis from pressure. Despite adequate use of external fixation, the injury may recur spontaneously, as shown by Duncan.⁹

Internal Fixation

In 1952, Pratt¹⁰ proposed the use of internal fixation of the joints of the finger with a Kirschner wire inserted through the distal phalanx and also fixing the proximal interphalangeal joint. Patients were immobilized in this manner up to six weeks with good results. With such splinting, the hand is left unencumbered by dressings and full motion of other digits is possible. Pratt¹¹ reported in 1964 that in the 925 mallet fingers treated in his office, only 11 per cent were treated by internal fixation with wire; those cases included open wounds requiring primary tendon repair, presence of large dorsal lip fragments and elective repairs. A total of 84 per cent were treated with a vinyl plastic gutter splint applied to the volar surface of the finger (Figure 3).

VOLAR SPLINT



FIGURE 3

The Pratt technique of immobilization of the finger in a plastic splint. Tape is used to hold the splint to the finger.

"Kirschner" Wire

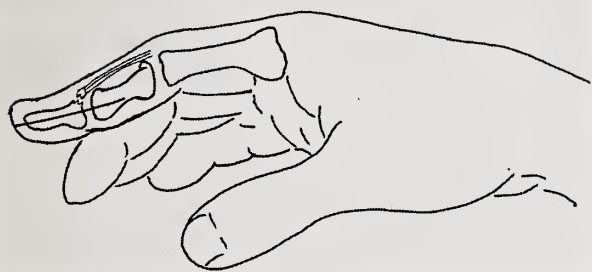


FIGURE 4

A Kirschner wire is inserted in the end of the finger and across the distal joint to hold the joint in extension.

Casseus¹² advised the use of intramedullary wire fixation across the distal joint (Figure 4). In 16 out of 20 injuries treated, he reported a loss of less than 10° of active extension at the distal joint. There was no joint damage reported in this survey.

Other methods of fixing the distal joint have been proposed such as that of Hillman.¹³ This method was used in nine patients successfully and consisted of placing #2 silk sutures transversing the distal joint; this served to extend the latter joint, leaving the proximal interphalangeal joint free.

Management

Care must be taken regarding the management of this injury when associated with avulsion of the tendinous insertion. With small fragment avulsions, conservative treatment may result in satisfactory apposition and healing; but if the fragment is large, apposition may occur by bony overgrowth from the distal phalanx resulting in extension losses of greater than 20°. Some authors state that all fractures associated with mallet finger should be fixed operatively; others imply that open fixation is applicable only if greater than one third of the joint surface is involved. There are few arguments in the literature supporting fixation of this injury, in its simple form, by open surgery.

The time having lapsed since the initial injury is important to some individuals. A mallet finger 10 days of age is considered an early injury by Bunnell; others consider an interval of up to two weeks criteria for treating the mallet finger as a new injury.¹⁴ Generally, conservative treatment tends to be more effective the earlier it is employed.

In those cases treated by splinting in the conventional methods above, a period of three to six weeks is used; presumably this time is used due to maximum collagen turnover occurring within the initial six weeks. Most authors concur to gradual improvement for six months after the initial period of immobilization.

As a general rule, the older the injury, the less is done toward immobilization of the digit. According to Bunnell, those patients presenting two months post trauma without prior treatment are usually palliated for pain and discomfort by splinting. Prolonged splinting may result in stiff joints in the involved finger, especially with regard to the proximal joint. Such a situation may demand attention in preference to the mallet finger.

Conclusion

Thorough history and physical examination of the patient with respect to the injury is necessary, including proper radiographs of the involved finger.

According to the literature, conservative management is the more convenient and most widely employed method of treating mallet finger. Many individuals have used varying types of splints and plaster casts for immobilization with fluctuating results. Recent methods of immobilization tend to suggest the use of more simple techniques of fixing the distal joint at 0° or some degree of hyperextension for a six week period (Figure 5).

TWO-BAR SPLINT



FIGURE 5

Two applicator sticks are taped together and then taped to the dorsum of the finger to hold the distal joint in extension.

The more difficult injuries, associated with bone fragments (type III and type IV—Smillie) and long-standing tendon avulsions, may require open surgery to correct the deformity.

Follow-up care is essential to the proper management of mallet finger.

Summary

A review of the literature is made regarding management of mallet finger. Some conclusions are drawn as to the proper care of this common tendon injury.

1140 Druid Park Avenue

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MALLET FINGER / Barnes, et al.

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HIGHLIGHTS OF THE MAG EXECUTIVE COMMITTEE OF COUNCIL, OCTOBER 11, 1970

APPOINTMENTS: Charles S. Jones, M.D., Atlanta, to the Committee on Medical Review and Negotiating, representing the Georgia Chapter, American College of Surgeons, replacing Harry D. Pinson, M.D., Augusta, who resigned.

COMMITTEES: Created an Ad Hoc Committee to study The Medical Practice Act, and named Harrison L. Rogers, Jr., M.D., Atlanta, as Chairman. Other members will include the Chairman of the Committee on Allied Health Careers, the Chairman of the Committee on Medical Education, a member of the Composite Board of Medical Examiners, the MAG Legal Counsel, Mr. John L. Moore, and J. Rhodes Haverty, M.D. Consultants suggested were: Mr. Trammell Vickery, Legal Counsel to the Georgia Hospital Association; Mr. Adam Jablonowski, MAG Assistant Director, Health Planning; Mr. Glenn Hogan, Executive Director, Georgia Hospital Association; and the Assistant Attorney General assigned to the Composite Board of Medical Examiners.

AMA COUNCILS AND COMMITTEES: Selected for nomination to the AMA, Tom Howell, Jr., M.D., Atlanta, to the Council on Occupational Health; J. W. Chambers, M.D., LaGrange, to the Council on Medical Service; F. William Dowda, M.D., Atlanta, to the Council on Long Range Planning and Development; and John S. Atwater, M.D., Atlanta, to the Joint Commission on Accreditation of Hospitals.

PEER REVIEW: Authorized the Committee on Medical Review and Negotiating to assume original jurisdiction over those claims found to be insoluble by local and district committees, and to proceed to process them based on information available. Also authorized the requesting of a formal hearing with the Social Security Administration and Prudential Insurance Company based on the procedural steps to be suggested by Mr. Douglass Richard, to consider formal protests to be lodged by several county medical societies concerning reimbursements for physicians' services by Prudential Medicare-B.

FOUNDATION FOR MEDICAL CARE: Authorized the President to sign the Articles of Incorporation and Charter Application officially creating the Georgia Foundation for Medical Care, and approved a mailing to all members of MAG by the founding Trustees, explaining the objectives of the Foundation.

INSURANCE: Approved in principle a resolution

to be finally approved at its next meeting, calling on Blue Cross-Blue Shield Plans in Georgia to aggressively sell their usual and customary fee contracts in preference to their other plans, and approved for introduction to the AMA House of Delegates a resolution calling for a restudy of liability insurance risk categories.

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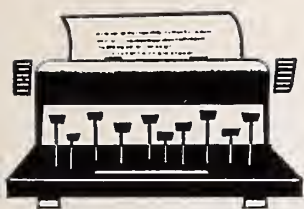
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The Abortion Survey

VIEWED FROM ANY VANTAGE POINT, one would have to observe that Georgia physicians have made a surprisingly liberal response to the questionnaire on abortions. The published results of the questionnaire appear in another place in this issue of the *Journal*. If, as I think one must, one assumes that physicians, by reason of training to preserve life, are traditionally conservative on the issue of abortion, the response is even more surprising.

Taken from a historical perspective, the changes in physicians' opinions could be considered astounding. Six or seven years ago I spoke to an outstanding group of obstetricians and gynecologists on the subject of sterilization, then a hot issue in the General Assembly of Georgia. During the questions and answers I learned to my concern that virtually all of those present approved the performance of abortions on women who had contracted rubella in the first trimester of pregnancy. Yet, at the time, the only lawful abortions in Georgia were those performed to save the life of the mother. On the other hand, soon afterwards, the famous incident occurred of the actress who had taken thalidomide in the first trimester of pregnancy. She tried to obtain an abortion in many states in the United States but finally went to Sweden for the abortion.

In 1967 and 1968, a number of us representing The Medical Association of Georgia, with considerable trepidation as to what physicians in Georgia might really think, spoke for legislation broadening the grounds for abortion to cover pregnancies resulting from rape, if necessary to prevent the birth of a defective fetus and to save the physical or mental health of the mother. It concerned us at the time as to whether we actually represented the majority opinion of the members of the Association. Yet today we read in another part of this *Journal* that 97.5 per cent of those responding to the survey favor the performance of abortion to save the mother's life and over 80 per cent favor all of the abortions allowed by the 1968 legislation.

Future Possibilities

Looking beyond the 1968 legislation and to the present status of Georgia law as modified by the three judge federal court in late August, 1970 (see "Georgia Abortion Law Unconstitutional," October, 1970, issue of this *Journal*, page 402), The Medical Association of Georgia, through its various Committees, has been studying what position to take on future legislation. More than half of those responding to the questionnaire favor the allowance of abortions when the mother is unmarried, when she has four children, for economic reasons, and for contraceptive failure. Almost half favor the allowance of abortion on request. When asked to respond as to the kind of abortion law preferred, over 75 per cent favored further liberalization beyond the 1968 statute.

Because the views are somewhat divided, it may be that no clear mandate to the various Committees of the Association comes out of the responses to the survey. However, it is also clear that it would not be representative of those responding to oppose liberalization of the abortion laws.

Prepared at the request of The Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Miller & Gaines, General Counsel to the Association.

Another point to observe is that when one studies the per cent of yes responses by type of practice, it becomes quite clear that while there is no very substantial difference as to the grounds for abortion provided by the 1968 legislation, there is considerable divergence of opinion in replies as to whether abortion should be allowed in cases of contraceptive failures, for economic reasons, and on request. The most conservative responses on those questions came from the obstetricians and gynecologists. The next most conservative responses came from the general practitioners. Since these are the physicians who must perform the abortions, I read their conservatism as reflecting the dislike of physicians for anything other than preserving life. Therefore, it seems to this writer that emphasis should be given by the Association to statutory protection of physicians who wish to decline to perform particular abortions. If abortions are to be allowed for social and economic reasons, then physicians should be allowed to decline to perform such abortions for moral, social, economic, religious, or ethical reasons. They should be protected in so declining even with respect to a patient whom they have agreed to serve.

Seldom has one seen so rapid a change in the opinion of the country on any subject. It appears that the physicians of Georgia have responded to the same reasons for change as the general public. Undoubtedly, the concern with ecology and the population explosion has influenced all of us, lay and professional persons alike.

John L. Moore, Jr.

County Society Officers' Conference Scheduled

THE 13TH ANNUAL County Society Officers' Conference will be held February 6-7, 1971, at the Sheraton Biltmore Hotel, Atlanta. Sponsored by the Public Relations Committee of MAG and by the direction of the House of Delegates, new members are, for the first time in the history of the Conference, also invited to participate.

New members will be given an over-all look at the Medical Association of Georgia, what the Association is attempting to accomplish, what services are available to new members and ways that new members can participate in the Association's programs. Activities of the American Medical Association will also be covered.

A panel discussion on County Society Officers' responsibilities will be presented for the benefit of the new officers. Physicians representing various county medical societies will discuss ways their societies implement effective programs geared to the betterment of health for their particular area. There will also be a panel discussion of health care problems, covering the process of claims review, with representatives of the MAG Committee on Medical Review and Negotiating, the Division of Health Care Administration of the State Health Department and a Carrier Consultant.

Extensive coverage of the Quackery issue will be provided by Joseph A. Sabatier, Jr., M.D., New Orleans, Chairman of the AMA Committee on Quackery. A panel discussion on Machine-Age Medicine will also be featured. On Sunday, discussion of the items mentioned will be continued, concluding with a keynote address by a prominent speaker.

A tour of MAG Headquarters will be followed by a social hour featuring the "Unpolished Brass," February 6, 1971, at the Sheraton Biltmore Hotel.



IT TAKES TWO TO TANGO

According to the Georgia Department of Public Health Biostatistic Service Report dated April 1, 1970, there was a total of 4,086 physicians registered in the State, catalogued as follows:

(1) Private Practice	3,221
(2) Institutional (Interns not included)	637
(3) Public Health (Does not include Military)	69
(4) Retired or Inactive	159

A number of those listed as Institutional Members actually are in private practice and are of the "hospital based" category.

Even so, some 3,700 Doctors are members of the Medical Association of Georgia; there are 67 medical societies and 38 auxiliaries. Some 400 physicians' wives are eligible to be members at large, but only 68 are such members (members at large constitute those physicians' wives and/or widows who reside in areas that do not have an Auxiliary Chapter).

The Auxiliary of the Medical Association of Georgia has some 2,250 members—this leaves some 1,450 eligible wives who are not members of the Auxiliary.

It is very true, and understandably so, that many of the wives are blessed with young children and much of their time is required in caring for these members of the family. But, it is very important, Doctor, that your wife be a member of the Auxiliary and contribute as much as possible to the organization.

The President of the Woman's Auxiliary of the Medical Association of Georgia, Mrs. Charles R. Smith, has been a regular attendant at the Medical Association of Georgia Council meetings and has contributed a great deal to that organization. I requested her to write me a letter regarding the Auxiliary, and she has graciously consented to do so; this letter herewith follows and is appropriately titled "It Takes Two to Tango."

*F. G. Eldridge, M.D., President
Medical Association of Georgia*

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- To secure sound medical legislation—
- Aid voluntary health organizations—
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Most important, the Auxiliary helps you to explain the viewpoint of the medical profession in its effort to work in the public interest in providing quality care for all people.

Your Medical Auxiliary is medicine's best partner.

Your Auxiliary knows her footwork. She is ready to perform.

She will welcome your "May we dance?"

*Mrs. Charles R. Smith
President, Woman's Auxiliary to the
Medical Association of Georgia*

SPIDERS WEAVE NEW WEB OF KNOWLEDGE ABOUT THE COMPLEX NATURE OF MAN

Are behavior patterns innate or learned? Can they be changed by enriching man's environment? Dr. Peter N. Witt, Director of Research for North Carolina's Department of Mental Health, seeks answers to those and other questions by studying the erratic webs spun by spiders on drugs.

Stored in a computer, an IBM System/360 Model 40, is a master web, the composite of many normal webs. Twenty-seven measurements are made from the drug-induced webs including size, shape, regularity, distance to the center, and distance between spirals. The computer compares webs with the master and records the numerical differences.

Webs spun by normal spiders free from dust, wind and the harassment of hungry predators are near invisible works of geometric art. Webs from drugged spiders vary from normal to bizarre patchworks of holes, awkward angles and incomplete spirals.

Difference in Drugs

Dr. Witt experiments with many classes of drugs including amphetamines, tranquilizers, barbiturates and hallucinogens. As a result, he is finding subtle differences in the way drugs affect man's brain and his body.

For example, two common hallucinogens, mescaline derived from a cactus and psilocybin from a mushroom, produce similar results when given to man. It appears they affect both mind and muscle.

The drugs cause hallucinations ranging from visions of monsters to a feeling of oneness with God, and, in some cases, slow breathing rates, heartbeat and coordination. But after feeding the drugs to spiders and analyzing their webs, Dr. Witt concludes the drugs may not be pharmacological equals. His experiments suggest mescaline primarily affects muscle; psilocybin the brain.

On mescaline, spiders build smaller webs with less regularity in spacing, indicating coordination is impaired. On psilocybin, webs are shorter with normal spacing, indicating the spider's drive or motivation is hampered.

One hundred fifty spiders are used in the daily tests. Fifty are a control group and receive no drug. Fifty take one drug, fifty another. It takes the spider only 20 minutes to build her web in a 20-inch-square glass and aluminum frame. Spiders live in a laboratory where early morning conditions, prime time for web building, can be simulated.

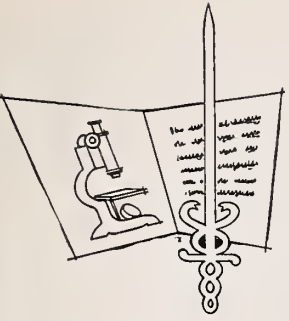
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NOT "ALAS, POOR YORICK . . ." but "alas, poor female"! Why should her organs of femininity produce such quandary in those physicians attempting to treat the malignancies of the same? More specifically, why is it that the leading site of carcinoma in the female still poses such a treatment problem—namely, carcinoma of the breast?

With the plethora of cases of this disease, the medical community seemingly should have long since been able to establish the preferential modes of therapy. Surely every physician desires to give his patient the best medical treatment that present medical knowledge will permit. There is, however, such voluminous literature on all stages of carcinoma of the breast that it is difficult, if not impossible, for the individual physician to select that which is "best" in any given situation. Any surgeon, radiotherapist or chemotherapist can glean from "the literature" reasons and justifications for almost any mode or combinations of modes of therapy that he should desire. The result of this situation is confusion. The conscientious physician is righteously concerned over his ability to treat the patient correctly when there are so many correct treatments and all are different. Simple excision of the breast carcinoma, simple mastectomy, radical mastectomy, extended radical mastectomy—any with or without radiation therapy, or radiation therapy alone are some of the many recommended modes of treatment the physician may consider in any given case of carcinoma of the breast.

There is, fortunately, a program under way on a national level that will eventually answer these questions; or, hopefully it will. In the meanwhile, what can the physicians who are treating these patients do?

The familiar standard radical mastectomy followed by irradiation if the axillary lymph nodes show metastases appears still to be the best treatment. Until proven unequivocally that they are superior, the other methods of treatment should be left to those places that can properly carry out a controlled study series. Of course, this recommendation applies only to the initial treatment of breast carcinoma without demonstrable spread distant to the regional lymph glands. Distant metastatic disease or recurrent disease brings into consideration additional modes of therapy such as hormone therapy or chemotherapy. It is not in the scope of this editorial to discuss this even more complex problem.

There are many renowned physicians advocating various methods of treatment. Some of them may eventually be proven correct. The private physician should apply the old standard treatments until the other methods are established as better.

200 E. 31st Street

* Medical Vice President, Chatham County Unit, American Cancer Society.



ANGINA PECTORIS TWO HUNDRED YEARS LATER*

MARK E. SILVERMAN, M.D.,** *Atlanta*

"But there is a disorder of the breast marked with strong and peculiar symptoms, considerable for the kind of danger belonging to it, and not extremely rare, which deserves to be mentioned more at length. The seat of it, and sense of strangling and anxiety with which it is attended, may make it not improperly be called angina pectoris. They who are afflicted with it, are seized while they are walking, (more especially if it be up hill, and soon after eating) with a painful and most disagreeable sensation in the breast, which seems as if it would extinguish life, if it were to increase or to continue; but the moment they stand still, all this uneasiness vanishes."

—William Heberden

THIS CLASSIC DESCRIPTION by William Heberden in 1772 has so admirably drawn the profile of the disease that little has been added to the clinical description of angina pectoris in the intervening two centuries. Heberden himself, however, recognized that the disease was not a homogeneous one and remarked "... some varieties may be met with. Some have been seized while they were standing still, or sitting, also upon first waking out of sleep." These patients have, however, also been lumped in the same category of "angina pectoris." In the last decade advances in coronary cineangiography have brought many correlations between the anatomy of the coronary arteries, the electrocardiogram, and the clinical findings. These studies have shown that the large, originally amorphous lump entitled angina pectoris may possibly be divided into smaller lumps. For example, some patients with angina pectoris have apparently normal coronary arteries. The cause of the angina pectoris in these patients is unclear. Proposed mechanisms include an abnormal stingy hemoglobin that binds oxygen tightly, small vessel disease not shown by coronary arteriography, and inexperienced interpretation of coronary angiograms. There are patients who may have angina pectoris because of a constricting band of myocardial muscle over the artery. Removal of the muscle band has abolished the symptoms in some cases. Angina can also occur with normal coronary arteries in patients with valvular aortic stenosis, muscular subaortic stenosis, pulmonary hypertension, and anemia.

New advances in coronary artery bypass surgery make it imperative to try to identify these various categories of angina pectoris, to describe an etiology and to assign a prognosis to each one, if possible. Recently we have seen another type of patient with a recognizable clinical presentation that offers an anatomic insight into the coronary arteries. This syndrome has been termed "variant angina" or "Prinzmetal's angina" and was described originally in 1959. It differs from Heberden's angina in several important respects. The anginal pain almost always

* From the Department of Medicine, Emory University School of Medicine and Piedmont Hospital, Atlanta, Georgia.

** Assistant Professor in Medicine, Emory University School of Medicine.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

comes at rest and is not typically provoked by exertion. It may recur at the same time each day. An electrocardiogram taken during the pain reveals transient ST segment elevation rather than T wave inversion. In contrast to angina pectoris, arrhythmias are common and include ventricular premature beats, ventricular tachycardia, and transient heart block.

Autopsy and cineangiographic studies have shown that these patients usually have only one major area of coronary artery narrowing and that the diseased artery can be incriminated by an analysis of the electrocardiogram. Since the right coronary artery nourishes the inferior area of the heart in about 90 per cent of the population, then ST elevation in II, III, and aV_f implicates this artery. Conversely, ST elevation in the anterior leads singles out the left coronary artery (usually the left anterior descending) as the culprit. These patients can be diagnosed by careful attention to the history and by using outpatient portable monitoring devices to record the transient ST segment elevation. Because the prognosis in these patients seems grim and because of the single major lesion, these patients may be ideal candidates for coronary bypass surgery.

Hopefully, continued analysis of these pain patterns and comparison with clinical, electrocardiographic and coronary cineangiographic findings will expose other categories of angina pectoris that will lead to a better understanding of the problem and a rational approach to therapy.

Emory University, 30322

LETTER TO THE EDITOR

Dear Dr. Woody:

Dr. George Swerdloff's account in your August, 1970, issue of the Byron festival was in many ways an accurate report of the medical events related to the gathering as we saw them. The efforts that he and his voluntary supporters made to "Pick Up The Ugly Baby" without hesitation warrants notice and appreciation since the medical problems at the festival were unimaginable.

We must point out, however, that along with Dr. Swerdloff's heroic attempts to overcome the tremendous medical load, there was a group of local physicians, nurses, and laymen already working up to 24-hour shifts for five days before the first facility was set up by the Atlanta group. We provided first-aid care around the clock and had physicians and/or nurses available on site for at least 10 hours daily every day during the week prior to, and 24 hours daily for the three days of the festival. We used only a few of the Atlanta supplies, ours being donated by local physicians and pharmacists in Warner Robins or purchased by the Methodist Churches of the area. All workers were volunteers.

Because of the efforts and contributions of these people, we suggest that Dr. Swerdloff's statement, "If we (he and his group) had not gone into the medical vacuum at Byron, there would have been no medical care," is not a fair one. The seven physicians, over 20 nurses, and innumerable lay personnel that manned our aid station in treating hundreds of youngsters each day for 10 days and provided Dr. Swerdloff with a

large part of his data would not agree that the "vacuum" analogy was appropriate.

We would agree, however, that the medical facilities at the festival were totally inadequate and conditions as pointed out by Dr. Swerdloff were sub-standard. The services that his group and ours provided were far from adequate. But it would have been catastrophic if they had not been there at all.

*Sincerely,
DAVID N. HARVEY, M.D.
Doctor's Clinic,
Warner Robins, Ga.*

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Egan, Richard W. Active—Glynn—Su	2432 Parkwood Drive Brunswick, Georgia 31520
Ellison, Carrol W. Active—Bibb—GP	235 Medical Court Forsyth, Georgia 31029
Gilbert, Clyde D. Active—Stephens—OBG	800 E. Doyle Street Toccoa, Georgia 30577
Horseman, Robert W. Active—Richmond—Anes	580 Martin Lane Augusta, Georgia 30904
Nazli, Mehmet H. Active—Spalding—Anes	604 S. 8th Street Griffin, Georgia 30223
Pinera, Antonio Service—Laurens—PM	VA Center Dublin, Georgia 31021
Stacy, L. David DE-2—DeKalb—Path	3rd USA Med. Lab. Ft. McPherson, Georgia 30330

PERSONALS

First District

Katrine Rawls Hawkins was certified as a Diplomat of the American Board of Family Practice, in October.

T. A. Peterson has been elected to a three-year term on the board of directors of the Georgia Easter Seal Society for Crippled Children and Adults.

Fifth District

Maxwell R. Berry, F. William Dowda and **William McDougall** spoke at the groundbreaking ceremony for W. Paces Ferry Hospital, in September.

John T. Godwin has been appointed chairman of the Committee on Health Manpower of the Metropolitan Atlanta Council for Health.

A. H. Letton has been elected vice-president and president-elect of the American Cancer Society.

Sixth District

Ernest A. Hensley has retired from the practice of medicine in Glascock, for health reasons.

Eighth District

Robert E. Perry has been elected chairman of a newly created citizens advisory committee, which will make recommendations to the State Health Department on establishing standards and issuing licenses to state clinical laboratories and blood and tissue banks.

Samuel Victor was installed as president of the Seaboard Coast Line Railroad Surgeon's Association in October.

Tenth District

J. W. Williams has been appointed to a four-year term on the Georgia Commission for Improvement of Education.

DEATHS

Mark P. Pentecost, Sr.

Mark P. Pentecost, Sr., retired Atlanta physician, died October 10 in a private hospital.

Born in Winder, Ga., Dr. Pentecost was graduated from the University of Georgia in 1909 and the Emory Medical School in 1913. A veteran of World War I, he was a member of the Peachtree Road Methodist Church, the American Medical Association, Medical Association of Georgia, the Fulton County Medical Society, the Masons, the Shrine and the Piedmont Driving Club.

Dr. Pentecost is survived by two daughters, a son and two sisters.

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FIRST NATIONAL CONGRESS ON HEALTH MANPOWER

John T. Godwin, M.D., *Atlanta*

In the continuing effort to provide adequate numbers of medical manpower and to increase the number of categories of allied health personnel, a recent meeting was sponsored by the Council on Health Manpower of the American Medical Association.

The Congress spent three days utilizing 18 different task groups, discussing improving manpower utilization, expanding manpower supply and improving systems of delivery.

Some of the recommendations and conclusions are as follows:

In developing new categories of personnel, physicians should take a leading role in clarifying specific tasks that can be performed by allied health workers.

No new licensing laws should be passed until long-range solutions relative to the various categories of workers can be worked out.

There is a maldistribution of physicians, and the AMA should assume leadership in determining the cause of the maldistribution and provide for aid to communities in solving the provision of services.

The AMA should direct itself toward the problem of primary care, and there should be more general physicians, who should be given a higher status by their colleagues.

Recommendations

Medical schools should reduce the number of specifically required classes and develop programs that will provide students with primary care experience in both rural and urban settings. New categories of health manpower should be further developed, such as physician's associates and assistants. They should perform physician-like tasks, be trained by physicians in medical settings, in programs accredited by a national medical body and operate under the supervision of a physician.

The above recommendations will be studied by the Congress for possible further action.

Much of the information presented in the discussions was a reiteration of what has been transpiring in this area since the community health service of the early '60's and the Johnson-era White House Conferences.

It does appear that there might be some recognition that the physician does play a significant role in health care and planning. Hopefully, our approach to the problems of the provision and delivery of health care may be improving, although there are many obstacles and changes ahead.

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and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction. Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy. We will be pleased to provide further information upon request.

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THE MONTH IN WASHINGTON

The American Medical Association challenged charges of widespread tax cheating by physicians and renewed its offer to cooperate with the government in the cracking down on dishonest doctors.

In letters to Sen. Russell B. Long (D., La.), chairman of the Senate Finance Committee, Walter C. Bornemeier, M.D., president of the AMA, answered the tax cheating charges and Ernest B. Howard, M.D., executive vice president of the AMA, renewed the offer of cooperation. But Howard also said that mandatory reporting of unassigned fees by insurance agencies would be an ineffective and unfair way to try to uncover doctors cheating on their income taxes on payments for their services under medicare and medicaid.

The tax-cheating charges grew out of testimony given by Meade Whitaker, who then was tax legislative counsel for the Treasury Department, at a hearing of the Senate Finance Committee during its consideration of changes in the medicare and medicaid programs. He said that many providers of services under the two health care programs might have "substantial deficiencies" in their income tax returns.

Distorted Charges

In a letter to Long and Sen. Wallace F. Bennett (R., Utah), a ranking minority member of the finance committee, Dr. Bornemeier said that the charges had been widely distorted in the press and these reports do the medical profession a serious injustice.

Whitaker testified that from an original list of 11,000 who received payments of \$25,000 or more for

services rendered under medicare and medicaid in 1968, 4,000 returns warranted a detailed audit by the IRS.

With preliminary audits completed on 3,000 of the 4,000 returns, there were indications that 1,500 of these showed "substantial deficiencies," the Treasury reported. "Substantial deficiencies" later were defined as being underpayments of more than \$100.

Dr. Bornemeier said that his testimony was being widely interpreted to mean either that one-third of the medical profession was cheating (4,000 of 11,000 cases to be audited) or that one-half of the profession was cheating (1,500 alleged offenders from 3,000 actual audits).

"Assuming the worst—that 1,500 doctors out of 11,000 are guilty of income tax irregularities—the correct proportion would be between 13 and 14 per cent rather than 33 or 50 per cent," Dr. Bornemeier said.

Asks for Specifics

The AMA president called on the Treasury Department to be specific in their charges since the interpretation by the press growing out of their testimony reflected on the profession as a whole.

"As of now," he continued, "there seem to be 1,500 cases where substantial deficiencies may exist. I think we should know what proportion of these cases represents cause simply for further examination and what proportion represents cases that may realistically be expected to end up with the fraud division of the IRS."

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(2) Samuel N. Workman, M.D.
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(3) Charles W. Neville, Jr., M.D.
Associate Professor of Psychiatry
and Medical Director

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"I think we should know what proportion of the serious cases involve physicians. I suspect the figures given include osteopaths, dentists, pharmacists, and optometrists and others eligible to receive medicare-medicaid payments."

Request Not a Defense

Dr. Bornemeier told Long that his request for documentation of these cases was not a defense for the dishonest physician or anyone else who attempts to falsify an income tax return.

"We are on record," the Chicago physician said, "as requesting examples of wrongdoing by doctors receiving payments under government health programs so that we may take action of our own."

Dr. Howard said that "the dishonest or incompetent physician hurts us just as much as he harms his government."

Dr. Howard said that a recent statement by Long that the AMA had been "completely forthright and honorable, and sought to shield no one" is "exactly our position."

The AMA official also noted that Long at a recent hearing of the finance committee had referred correctly to previous requests by the AMA that it be given examples of suspected chicanery by physicians in government health programs "so that we might take our own action."

As for mandatory reporting of unassigned medical payments—those given to the patient rather than to the physician—Dr. Howard said such a requirement "would not provide the Internal Revenue Service with helpful and meaningful data." He urged rejection of such an amendment proposed by the Treasury Department. A joint House-Senate conference committee rejected it last year in considering tax reform legislation.

Proposed Reports

The Treasury Department proposed that Blue Cross-Blue Shield organizations, medicare and medicaid agencies, and other health insurance carriers be required to report unassigned payments for medical services.

Dr. Howard pointed out that millions of patients have more than one health insurance policy and may collect total benefits exceeding the physician's charge, and that some patients even may not use the insurance payment to compensate the physician. Physicians also would have to set up costly additional bookkeeping record procedures to list separately and in detail each charge to a patient in excess of \$25, the AMA official said.

"The proposal of the Treasury Department would place physicians in a unique category under our tax laws," Dr. Howard said. "We know of no other provision in the tax laws which singles out one class of individual taxpayers, requiring payers to report to the IRS individual payments made to taxpayers as well as the annual aggregate amount of such payments."

"We believe . . . that the proposed . . . amendment is unfair and discriminatory and would do little to accomplish any goal for an improved system. Instead, as an additional cost burden, it would place further pressure on the cost of medical care."

Presidential Praise

President Nixon, at a bill-signing ceremony, praised the new Drug Abuse Act for providing "a forward looking program" for treatment of drug addiction as well as strengthening the government's law enforcement powers in the field.

The new law provides for the Department of Health, Education and Welfare running extensive programs for

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WASHINGTON / Continued

the treatment and rehabilitation of drug users and for antidrug education. It authorizes HEW's National Institute of Mental Health to spend \$189 million over three years to build and staff treatment facilities, to support rehabilitation programs and to increase anti-drug education programs. Another \$1 million is authorized for creation of a presidential commission on marijuana.

State comprehensive health plans getting federal aid must now include drug abuse programs, and an Administration spokesman suggested that all states model their drug control laws on the federal statute.

Modified Legislation

Before final passage, Congress modified the original legislation to meet many of the objections of the medical profession against a proposal that would have allotted most classification powers and research control to the Justice Department. The attorney general can declare drugs as dangerous but he is bound by HEW's medical and scientific evaluations.

The strengthened enforcement provisions are aimed at the drug pusher with lighter penalties for drug possession, particularly by minors. Federal first offense cases for drug users are lowered from felonies to misdemeanors. Under this provision, a person found guilty of possessing marijuana for the first time will not necessarily be subjected to an automatic stiff jail

sentence. But to facilitate arrest of pushers, the controversial "no-knock" clause was retained.

Requirements as to records kept by a physician remain as under the old narcotics law except where he regularly dispenses a non-narcotic drug and charges for it.

The new law broadens the former narcotics statute to include, with varying restrictions and controls, amphetamines, barbiturates and other drugs ruled dangerous. At the start, controls will be drastically tightened over marketing the liquid form of amphetamines which can be taken by injection.

Companies producing or distributing a long list of commonly prescribed stimulants, depressants and tranquilizers will be subject for the first time to federal registration requirements. The Narcotic Bureau also now has a new power to set production quotas for such non-narcotic drugs.

Law Enactment Praised

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, praised Congress and the Administration for enactment of the law:

"Drug abuse has become a frightening problem for millions of Americans. It is absolutely proper for the federal government to exercise this type of aggressive leadership to stem the use of physically and psychologically damaging illicit substances, to control the misuse of legitimate medicines produced for the health and welfare of citizens, and to support rehabilitative needs for victims of the drug problem."

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Index

Volume 59—1970

Month	Pages	Month	Pages	Month	Pages
January	1-42	May	169-198	September	351-384
February	43-82	June	199-276	October	385-414
March	83-130	July	277-312	November	415-436
April	131-168	August	313-350	December	437-470

Key to letter abbreviations appearing before page numbers:

C—Cancer Page
E—Editorial
H—Heart Page
L—Legal Page

AUTHOR'S INDEX

Authors	Page
Appel, James Z., M.D.	424
Barnes, Stephen N., M.D.	455
Barrow, J. Gordon, M.D.	151
Bartel, Alan G., M.D.	284
Becton, James L., M.D.	455
Braucher, Charles L., Ph.D.	175
Brice, B. S., M.D.	147
Bryant, Milton F., M.D.	415
Buckalew, V. M., Jr., M.D.	H-400
Cardosa, David, M.D., F.A.C.O.G.	181
Carr, Albert A., M.D.	360
Carter, Leon, Jr., M.D.	150
Christian, Joe D., Jr., M.D.	455
Clark, Mrs. S. William, Jr.	188
Crews, Thomas L., M.D.	135
Crumbly, A. J., M.D.	108
Daniel, Ernest F., M.D., J.D.	140
Davies, Nicholas E., M.D.	117
Duval, Addison M., M.D.	121
Eldridge, F. G., M.D.	191, 272, 297, 333, 370, 396, 429, 461
Ellison, Robert G., M.D.	135, H-301
Evans, Orinda D.	L-339
Finch, Henry M., M.D., F.A.C.S.	C-299
Fletcher, Gerald F., M.D.	60
Frank, Martin J., M.D.	135
Freeman, Malcolm G., M.D.	173, 437
Galloway, Ronald F., M.D.	180, 392
Gilbert, Charles A., M.D.	H-72
Godwin, John T., M.D.	467
Gordon, Arthur	30
Grady, Edgar D., M.D.	108
Graves, William L., Ph.D.	437
Greenblatt, Robert B., M.D.	344
Gurr, Steve	11
Hagan, Hon. C. Elliott, M.C.	23
Hagler, William S., M.D.	102
Hames, Curtis G., M.D.	H-194, 284
Harkess, James W., M.D.	420
Harper, Harry T., Jr., M.D.	135, H-372

Authors	Page
Harrison, Charles E., Jr., M.D.	117
Haverty, J. Rhodes, M.D.	115, 169, 328
Howell, Tom S., Jr., M.D.	422
Huger, William E., Jr., M.D.	50
Humphrey, Loren J., Jr., M.D., Ph.D.	C-31
Jacobs, Julian, M.D.	292
Jarrett, William H., M.D.	102
Jelenko, Carl, III, M.D.	E-427
Johnson, Thomas D., M.D.	H-433
Jolley, Fleming L., M.D.	E-267
Jove, Donna Franco, M.D.	143
Jowdy, Albert W., Ph.D.	175
Keys, Ancel, Ph.D.	355
Kitzmler, K. William, M.D.	385
Korn, Morton, M.D.	418
Lamis, Pano A., M.D., F.A.C.S.	C-431
Lee, J. Moultrie, M.D.	C-463
McCain, John R., M.D.	165, 423
McDaniel, J. G., M.D.	E-28
McDonough, Paul G., M.D., F.A.C.O.G.	181
McGandy, R. B., M.D.	62
McKenzie, Donald J., M.D., F.A.C.S.	290
Matthews, Sanford J., M.D.	8
Montgomery, John R., M.D.	1
Moore, John L.	L-36, L-74, L-163, L-303, L-374, E-459
Nolan, Thomas R., M.D.	108
Owens, J. L., Jr., M.D.	E-154
Owings, J. M., M.D.	147
Partin, Clyde, Ph.D.	351
Platt, Fletcher N.	16
Presley, George D., M.D.	102
Rogers, Harrison L., M.D.	452
Sanders, J. Larry, M.D.	360
Shea, Pat C., Jr., M.D.	E-294
Silverman, Mark E., M.D.	H-464
Skorapa, Victor, Jr., M.D.	143
Smith, Mrs. Charles R.	461
Smith, J. H., M.D.	147
Smith, Robert B., III, M.D.	143
Somers, Anne R.	54
Stare, F. J., M.D.	62
Stegeman, John F., M.D.	156
Story, Frank C., M.D.	323
Stuart, William H., M.D.	E-331
Swerdlloff, George R., D.D.S.	325
Teabeaut, J. Robert, M.D.	135
Temple, T. E., Jr., M.D.	313
Thigpen, Patricia A.	105
Thoroughman, James C., M.D.	143
Torpin, Richard, M.D.	323
Train, John Kirk, M.D.	76, 127, 157
Trice, John, M.D.	365
Vaux, Kenneth, Th.D.	447
Vickery, Trammell, E.	L-374

Authors	Page
Waldron, Charles A., D.D.S., M.S.D.	C-159
Wammock, Hoke, M.D.	C-192
Watts, N. B., M.D.	313
Wenger, Nanette Kass, M.D.	60, H-161
White, Paul Dudley, M.D.	131
Wilbur, Joseph A., M.D.	H-337
Willard, William R., M.D.	277
Williams, Virgil B., M.D.	282
Wilson, John Page, M.D.	C-335, C-398
Witte, John J., M.D.	387
Wyatt, C. J., Jr., M.D.	147
Yeh, Thomas J., M.D.	319

SUBJECT INDEX

— A —

ABORTION

Physician Attitudes Toward Hospital Abortion in Georgia—1970 (Freeman, Graves)	437
The Abortion Survey (Moore)	E-459

ABDOMINAL TRAUMA

Injury to the Kidney and Urinary Bladder in Blunt Abdominal Trauma (McKenzie)	290
---	-----

ABSTRACTS

Abstracts by Georgia Authors	305, 369
------------------------------	----------

AMERICAN MEDICAL ASSOCIATION

1970—AMA Annual Convention	188
AMA Appoints Staff Member to Strengthen SAMA Liaison	61
Highlights of the AMA House of Delegates Meeting	38
Highlights of the AMA House of Delegates Meeting, June 21-25, 1970	341
Report on Congress on Medical Education (Haverty)	115

AORTIC ANEURYSMS

Surgical Treatment of Abdominal Aortic Aneurysms (Bryant)	415
---	-----

ATLANTA GRADUATE MEDICAL

27th Annual Session, Atlanta Graduate Medical Assembly (Barrow)	151
---	-----

— B —

BACTERIOLOGY

Dicloxacin in the Treatment of Pure Staphylococcal and of Mixed Staphylococcal-Streptococcal Infections of Childhood (Matthews)	8
---	---

BLOOD GASES

Arterial Blood Gas Values (Yeh)	319
---------------------------------------	-----

BLOOD LIPIDS

The Potential for Reducing the Risk Associated with Elevated Blood Lipids (McGandy, Stare)	62
A Practical, Palatable and Prudent Way of Eating (Keys)	355

BLUE SHIELD CONFERENCE

The Blue Shield Annual Program Conference (McCain)	423
--	-----

BURNS

Thermal Burns (Shea)	E-294
----------------------------	-------

— C —

CALENDAR OF MEETINGS

10, 49, 99, 139, 187

CANCER

Angiography in Cancer Detection (Lamis)	C-431
Breast Cancer Treatment—A Problem of Selection (Lee)	C-463
Cancer Control (Wamrock)	C-192
A Cookbook of Anti-Cancer Chemotherapy for Solid Tumors (Grady, et al.)	108
Does Man React Against Cancer Immunologically? (Humphrey)	C-31
Enterostomal Therapy—A New Approach to Ostomy Care (Finch)	C-299
Quality of Survival—Part I (Wilson)	C-335
Quality of Survival—Part II (Wilson)	C-398
Tumors of Minor Salivary Gland Origin (Waldron)	C-159
The Value of Bronchial Washing Cytology in the Diagnosis of Bronchogenic Cancer (Galloway) ..	180

CARDIOLOGY

Ball Variance: Potentially Lethal Degeneration of the Starr-Edwards Aortic Valve Poppet (Crews, et al.) ..	135
The Challenge of Prevention of Cardiovascular Diseases (White) ..	131
Clinical Management of Patients with Prosthetic Valves (Korn) ..	418
Heart Rate Measurements of Drivers with the Highway Systems Research Car (Platt) ..	16
Intensive Coronary Care in a 42-Bed Rural Hospital (Bartel, Hames) ..	284
Primary Myocardial Disease: Clinical Characteristics (Wenger, Fletcher) ..	60
Some Immunologic Aspects of Cardiac Transplantation (Montgomery) ..	1
Unusual Reactions to Common Cardiovascular Drugs (Harrison, Davies) ..	117
Viral Valvulitis ..	E-70

CHEMOTHERAPY

Chemotherapy in Private Psychiatric Practice (Trice) ..	365
A Cookbook of Anti-Cancer Chemotherapy for Solid Tumors (Grady, et al.) ..	108
Dicloxacin in the Treatment of Pure Staphylococcal and of Mixed Staphylococcal-Streptococcal Infections of Childhood (Matthews) ..	8
Malaria in Georgia (Jacobs) ..	292

COMMUNICABLE DISEASE

Malaria in Georgia (Jacobs) ..	292
Viral Valvulitis ..	E-70

COMMUNITY HEALTH SERVICES

The Central Role of the Hospital in Community Health Services (Somers) ..	54
---	----

COMMUNITY MENTAL HEALTH PROGRAMS

Major Difficulties in Successful Mental Health Program Developments on Community Health Services (Somers) ..	54
--	----

COMPREHENSIVE HEALTH PLANNING

Physician Manpower in Georgia (Ga. Off. of Comp. Health Plan.) ..	43
---	----

COMPUTERS AND MEDICINE

Use of Computers in the Study of Retinal Disease and Retinal Detachment (Hagler, et al.) ..	102
---	-----

CONGENITAL ABNORMALITIES

Placenta Biloba in Uterus Arcuatus (Torpín, Story) ..	323
---	-----

COORDINATED HOSPITAL-MEDICAL SOCIETY MEETINGS

Coordinated Hospital Staff-County Medical Society Meetings (Huger) ..	50
---	----

COUNTY MEDICAL SOCIETIES

The Individual Member, The County Society, and The Medical Association of Georgia (Rogers) ..	452
The Responsibilities of a County Medical Society President (Galloway) ..	392

— D —

DEATHS

Brown, Jesse Bryan, Jr.	409
Busch, John Fabian	306
Cason, Cecil D.	167
Daniel, Ben E.	379
Drane, Robert	274
Ezzard, Thomas M.	275
Ferrell, Thomas J., Sr.	307
Ferguson, Ira A.	167
Furst, Stephen E.	275
Hillis, W. Wycliffe, Jr.	38
Hopkins, Anne McHenry	409
Johnson, Robert Wayne	379
McCord, Ralph Butler	347
McLaughlin, Charles K.	347
Newsome, Emory Glenwood	435
Norton, John Harvey, Jr.	197
Pentecost, Mark P., Sr.	466
Pierce, Lovick W.	347
Redmond, C. G.	197
Sassos, George	167
Selman, W. A.	275
Tailer, William H.	129
Thompson, John B., Jr.	347
Webb, Marcus L.	275

DERMATOLOGY

Laser Treatment of Tattoos and Angiomas (Kitzmiller) ..	385
---	-----

DRUG ABUSE

Who Picks Up The Ugly Baby? (Swerdlhoff) ..	325
---	-----

DRUG THERAPY

Unusual Reactions to Common Cardiovascular Drugs (Harrison, Davies) ..	117
--	-----

— E —

EDITORIALS

The Abortion Survey (Moore) ..	E-459
1970—AMA Annual Convention ..	E-188
Cerebrovascular Disease and Oral Contraceptives ..	E-125
Committee Conclave ..	E-296
County Society Officers' Conference Scheduled ..	E-460

Highlights 1970 Georgia General Assembly ..	E-154
Highlights of the 1970 MAG Annual Session ..	E-268
If You Don't Vote—Don't Gripe ..	E-395
Jablonowski New Addition to MAG Staff ..	E-428
L-Dopa and Parkinsonism (Stuart) ..	E-331
Medical Aspects of Sports ..	E-369
Our New Headquarters—Here and Now (McDaniel) ..	E-28
Pitfalls in the Catheterization of the Snake (Jolley) ..	E-267
Preventing Death in a Ditch (Jelenko) ..	E-427
Rural Health Conference Slated for September ..	E-331
Thermal Burns (Shea) ..	E-294
Viral Valvulitis ..	E-70
W. C. Mitchell of Smyrna Installed as President-Elect ..	E-267
Welcome to Jekyll for the Annual Session (Owens) ..	E-154
Why a Woman's Auxiliary? (Clark) ..	E-188

EMERGENCY MEDICAL SERVICES

Disaster Preparedness in Georgia (Williams) ..	282
Pitfalls in the Catheterization of the Snake (Jolley) ..	E-267
Preventing Death in a Ditch (Jelenko) ..	E-427

ENDOCRINOLOGY

Graves' Disease, Gastrointestinal Dysfunction, and Muscle Weakness (Temple, Watts) ..	313
Non-Contraceptive Use of Progestins (McDonough, Cardosa) ..	181

— F —

FAMILY PRACTICE

Recognition of the National Need for Education of Physicians in Family Practice (Willard) ..	277
--	-----

— G —

GAMPAC

Rx for Good Government—A Congressman's View (Hagan) ..	23
--	----

GASTROINTESTINAL DISEASES

Graves' Disease, Gastrointestinal Dysfunction, and Muscle Weakness (Temple, Watts) ..	313
---	-----

GENERIC DRUGS

A Study of Physicians' Attitudes Concerning Generic Prescribing (Braucher, Jowdy) ..	175
--	-----

— H —

HEALTH CARE DELIVERY

Who Picks Up the Ugly Baby? (Swerdlhoff) ..	325
---	-----

HEALTH MANPOWER

First National Congress on Health Manpower (Godwin) ..	467
Physician Manpower in Georgia (Ga. Off. of Comp. Health Plan.) ..	43
Recognition of the National Need for Education of Physicians in Family Practice (Willard) ..	277

HEALTH STATISTICS

Health Statistics Used in "Erratic Numbers Game" (Appel) ..	424
---	-----

HEART PAGE

Angina Pectoris Two Hundred Years Later (Silverman) ..	H-464
Clinical Usage of the Newer Diuretic Agents (Buckalew) ..	H-400
Coronary Artery Collateral Circulation—Myth or Major Compensation Mechanism? (Gilbert) ..	H-72

Heart Murmurs in Pregnancy (Bleich)	H-34
Hypertension: An Old Challenge with New Opportunity (Johnson)	H-433
Iatrogenic Heart Disease (Harper)	H-372
The Increasing Role of Surgery for Coronary Artery Disease (Ellison)	H-301
Pulmonary Embolism and The Urokinase Pulmonary Embolism Trial (Wenger)	H-161
The Significance of Elevated Blood Pressure in the Young (Wilber)	H-337
Stress and Heart Disease (Hames)	H-194

HOSPITALS

The Central Role of the Hospital in Community Health Services (Somers)	54
--	----

— I —

IMMUNOLOGY

Some Immunologic Aspects of Cardiac Transplantation (Montgomery)	1
---	---

INFECTIOUS DISEASE

Rubella and Rubella Vaccines— Current Concepts (Witte)	387
---	-----

INTENSIVE CARE UNITS

"Crossing the Bar" at the Intensive Care Unit (Stegeman)	156
Intensive Coronary Care in a 42-Bed Rural Hospital (Bartel, Hames)	284

— K —

G. LOMBARD KELLY

G. Lombard Kelly—A Man To Remember (Greenblatt)	344
--	-----

— L —

LASER THERAPY

Laser Treatment of Tattoos and Angiomas (Kitzmiller)	385
---	-----

L-DOPA

L-Dopa and Parkinsonism (Stuart)	E-331
--	-------

— M —

MALARIA

Malaria in Georgia (Jacobs)	292
-----------------------------------	-----

MALPRACTICE

Medical Malpractice vs. Industrial Malpractice (Daniel)	140
--	-----

MATERNAL AND INFANT WELFARE

Report of the Subcommittee for Perinatal Mortality and Morbidity (Freeman)	173
--	-----

MEDICAL ASSOCIATION OF GEORGIA

ANNUAL SESSION 1970

The Annual Session—1970	35
Official Call	83
Official Proceedings	
House of Delegates—First Session	201
House of Delegates—Second Session	229
First General Business Session	199
Second General Business Session	200
Third General Business Session	227
Program	88
Welcome to Jekyll (Owens)	E-154
Woman's Auxiliary	93
Aven Receives Award	77

COMMITTEES

Committee Conclave	E-296
Emergency Medical Services	179
Leadership Conference	149

Rural Health Conference Slated for September	E-331
---	-------

EXECUTIVE COMMITTEE OF COUNCIL

March 14, 1970	160
June 21, 1970	318
July 26, 1970	359
August 16, 1970	368
October 11, 1970	458

NEW MEMBERS

78, 129, 166, 196, 274, 306, 346, 378, 408; 435, 466	
---	--

PERSONALS

38, 78, 129, 166, 197, 274, 306, 346, 378, 408, 435, 466	
---	--

SOCIETIES

38, 78, 129, 166, 196, 274, 306, 346, 378	
The Individual Member, The County Society, and The Medical Association of Georgia (Rogers)	452
Inside MAG Headquarters (Thigpen)	105
Open Letter to MAG Members (McCain)	165
Services Available Through MAG (Haverty)	328

MEDICAL CARE DELIVERY

Distribution of Physicians Rendering Pediatric Care in Georgia (Haverty)	169
---	-----

MEDICAL HISTORY

Richard Dennis Arnold, Savannah Physician and Unionist in the Years of Crisis, 1832-1861 (Gurr)	11
---	----

MEDICINE AND RELIGION

Ethical Aspects of "The Final Revolution": Mind Manipulation and Judeo-Christian Ethics (Vaux)	447
--	-----

MEDICO-LEGAL

California Anti-Trust Action Against AMA (Moore)	L-303
California Anti-Trust Suits Against Malpractice Insurers (Moore)	L-74
Georgia Abortion Law Unconstitutional (Moore)	L-402
1970 Georgia Statutes (Moore)	L-163
New Federal and State Garnishment Laws (Evans)	L-339
Staff Privileges in Private Hospitals (Moore)	L-36
Voluntary Sterilization Law Recommended Forms (Moore, Vickery)	L-374

MYOPATHIES

Graves' Disease, Gastrointestinal Dysfunction, and Muscle Weakness (Temple, Watts)	313
--	-----

MONTH IN WASHINGTON

42, 79, 123, 308, 347, 380, 412, 468	
--------------------------------------	--

— N —

NUTRITION

The Potential for Reducing the Risk Associated with Elevated Blood Lipids (McGandy, Stare)	62
A Practical, Palatable and Prudent Way of Eating (Keys)	355

— O —

OBSTETRICS

Non-Contraceptive Use of Progestins (McDonough, Cardosa)	181
Placenta Biloba in Uterus Arcuatus (Torpin, Story)	323

OPHTHALMOLOGY

Use of Computer in the Study of Retinal Disease and Retinal Detachment (Hagler, et al.)	102
---	-----

ORAL CONTRACEPTIVES

Cerebrovascular Disease and Oral Contraceptives	E-125
--	-------

ORTHOPEDICS

Mallet Finger—A Review of the Literature (Becton)	455
--	-----

— P —

PARKINSONISM

L-Dopa and Parkinsonism (Stuart)	E-331
--	-------

PATHOLOGY

The Value of Bronchial Washing Cytology in the Diagnosis of Bronchogenic Cancer (Galloway)	180
--	-----

PEDIATRICS

Benefits of Vigorous Physical Activity for Young Boys (Partin)	351
Dicloxacillin in the Treatment of Pure Staphylococcal and of Mixed Staphylococcal-Streptococcal Infections of Childhood (Matthews)	8
Distribution of Physicians Rendering Pediatric Care in Georgia (Haverty)	169

PHYSICAL FITNESS

Benefits of Vigorous Physical Activity for Young Boys (Partin)	351
---	-----

POETRY

"Crossing The Bar" at the Intensive Care Unit (Stegeman)	156
---	-----

PORPHYRIA

Acute Intermittent Porphyria (Carr, Sanders)	360
---	-----

PRESIDENT'S LETTER

Abortion: What Do <i>You</i> Think? (Eldridge)	396
Brother, Can You Spare Ninety Seconds? (Gordon)	30
Did You Know That . . . ? (Eldridge)	370
A Fond Farewell (Train)	157
From Out of the Past (Eldridge)	429
It Takes Two to Tango (Eldridge)	461
Jekyll Island—1970 (Eldridge)	272
More on Additional Dues (Train)	127
Peer Review! Who Needs? We Do! (Eldridge)	297
Reference Committee J (Eldridge)	333
Sutton's Law (Train)	76
We Must Be Above Reproach (Eldridge)	190

PREVENTIVE MEDICINE

The Challenge of Prevention of Cardiovascular Diseases (White)	131
A Practical, Palatable and Prudent Way of Eating (Keys)	355
The Potential for Reducing the Risk Associated With Elevated Blood Lipids (McGandy, Stare)	62
Rubella and Rubella Vaccines— Current Concepts (Witte)	387

PRIMARY CARDIOMYOPATHY

Primary Myocardial Disease: Clinical Characteristics (Wenger, Fletcher)	60
--	----

PROSTHETIC HEART VALVES

Ball Variance: Potentially Lethal Degeneration of the Starr-Edwards Aortic Valve Poppet (Crews, et al.)	135
Clinical Management of Patients with Prosthetic Valves (Korn)	418

PSYCHIATRY

Chemotherapy in Private Psychiatric Practice (Trice)	365
---	-----

PSYCHOSOMATIC MEDICINE

When All the Tests Are Negative (Carter)	150
---	-----

— R —

RICHARD DENNIS ARNOLD

- Richard Dennis Arnold, Savannah
Physician and Unionist in the Years
of Crisis, 1832-1861 (Gurr) 11

RURAL HOSPITALS

- Intensive Coronary Care in a 42-Bed
Rural Hospital (Bartel, Hames) 284

— S —

SOCIALIZED MEDICINE

- Medicine and Government (Harkess) 420

SPLENIC RUPTURE

- Spontaneous Rupture of the Spleen
(Owings, et al.) 147

SURGERY

- Some Immunologic Aspects of Cardiac
Transplantation (Montgomery) 1
Spontaneous Rupture of the Spleen
(Owings, et al.) 147
Surgical Treatment of Abdominal
Aortic Aneurysms (Bryant) 415
An Unusual Case of Pheochromocytoma
(Thoroughman, et al.) 143
The Value of Bronchial Washing
Cytology in the Diagnosis of
Bronchogenic Cancer (Galloway) .. 180

— T —

TRAFFIC SAFETY

- Heart Rate Measurements of Drivers
with the Highway Systems Research
Car (Platt) 16

TUMORS

- A Cookbook of Anti-Cancer
Chemotherapy for Solid Tumors
(Grady, et al.) 108
An Unusual Case of Pheochromocytoma
(Thoroughman, et al.) 143

— U —

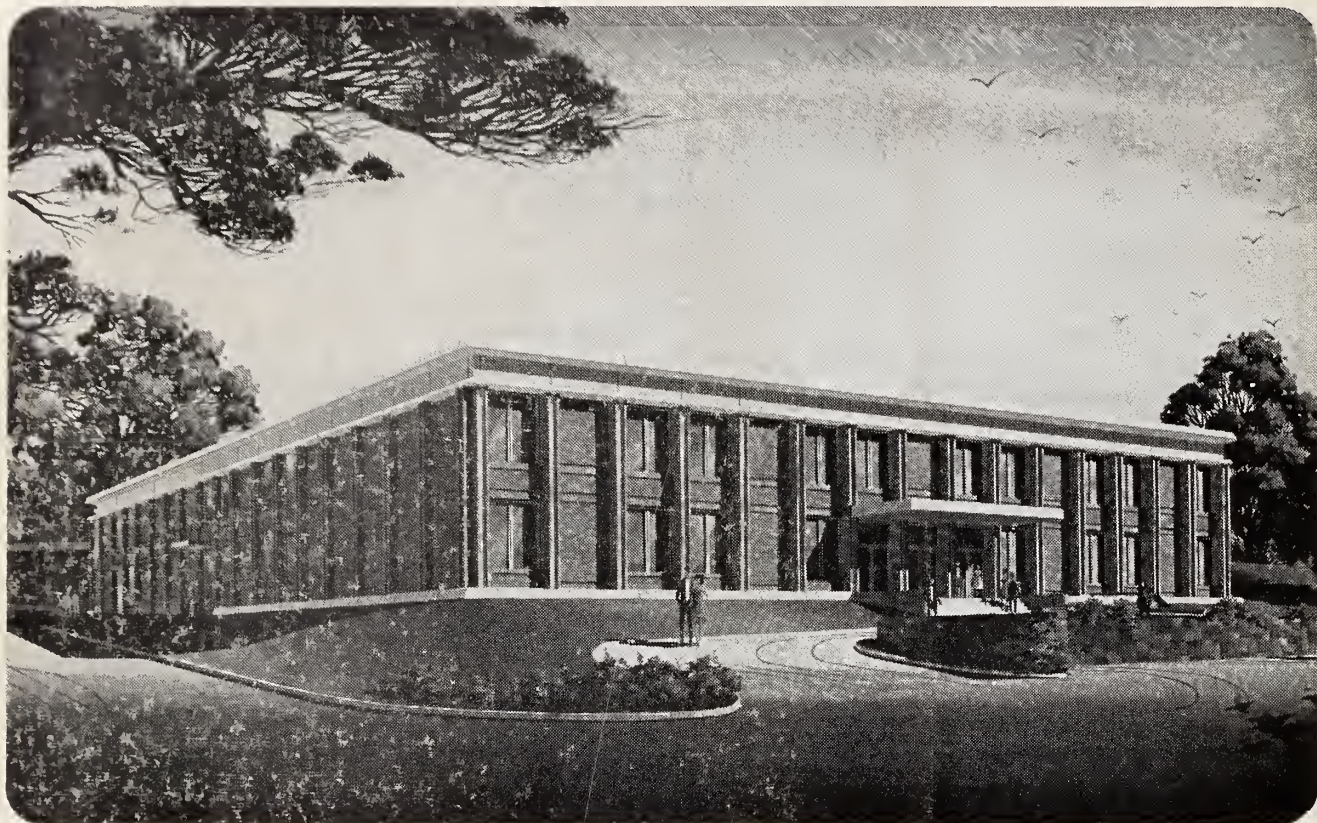
UROLOGY

- Injury to the Kidney and Urinary
Bladder in Blunt Abdominal Trauma
(McKenzie) 290

— W —

WORKMEN'S COMPENSATION

- Recent Developments in the Status of
Workmen's Compensation (Howell) . 422



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